

Exhibit T

Redacted

CONFIDENTIAL - SUBJECT TO PROTECTIVE ORDER

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UNITED STATES DISTRICT COURT
DISTRICT OF MINNESOTA

Michelle Simha, as
Trustee for the
Next-of-Kin of Noah
Leopold,

Plaintiff, Civil File No.
24-CV-01097-JRT-DTS

vs.

Mayo Clinic,

Defendant.

DEPOSITION OF MAURICIO VILLAVICENCIO

Volume I, Pages 1 - 153

August 14, 2024

(The following is the deposition of Mauricio Villavicencio, taken pursuant to Notice of Taking Deposition, via video, at Mayo Clinic, Legal Department, 100 Second Street SW, Rochester, Minnesota, commencing at approximately 1:15 p.m., August 14, 2024.)

CONFIDENTIAL - SUBJECT TO PROTECTIVE ORDER

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APPEARANCES:

On Behalf of the Plaintiff:

Brandon Thompson

Bibeane Metsch-Garcia (via Zoom)

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On Behalf of the Defendant:

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ALSO PRESENT:

Ron Huber, Videographer

Anna C. Messerly, Ciresi Conlin

Maggie Palmisano, Ciresi Conlin (via Zoom)

Sheri Peterson, Mayo Clinic

Michelle Simha (via Zoom)

Norman Leopold (via Zoom)

Karen Leopold (via Zoom)

Jenna Shulman (via Zoom)

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PROCEEDINGS

THE VIDEOGRAPHER: We're on the record.

Today is August 14th, 2024. The time is 1:15

p.m. Today's case caption is Simha versus Mayo

Clinic. The witness for today's deposition is

Mauricio Villavicencio.

At this time the court reporter will

swear the witness.

(Witness sworn.)

MR. BRANTINGHAM: Brandon, I'm sorry,

before you proceed, can I just --

I just want to put on the record that

I -- that I provided the emails to you --

MR. THOMPSON: Oh, sure.

MR. BRANTINGHAM: -- that I believe

completes the production of responsive emails

from Dr. Villavicencio. Obviously we'll talk

about anything about that further, I just wanted

to put it on the record --

MR. THOMPSON: Sounds good.

MR. BRANTINGHAM: -- lest I forget when

it happened.

MR. THOMPSON: Sounds good.

MR. BRANTINGHAM: Please proceed.

MAURICIO VILLAVICENCIO,

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Recipient Information Sharing,

Mayo_Leopold_0024837 to '4844

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called as a witness, being first duly

sworn, was examined and testified as

follows:

EXAMINATION

BY MR. THOMPSON:

Q. All right. Doctor, have you ever had

your deposition taken before?

A. No.

Q. So just a couple of quick ground rules

to make sure that we get on the same page and we

get a nice, clean record.

Number one, try to keep your voice up.

You're a little bit of a soft talker so far. It

makes the court reporter's job easier if you can

speak as loudly as you can. Okay?

A. Sure.

Q. Let's try really hard not to talk over

one another. I'm bad about that, as we've

established over the course of the last few

days, but I'm going to try hard not to talk over

you and you try hard not to talk to over me.

Okay?

A. Sounds good.

Q. Verbal responses like yeses and nos are

really good; shakes of the head and nods and

2 (Pages 2 to 5)

<p style="text-align: right;">Page 6</p> <p>1 grunts or uh-huhs and huh-uhs are not good 2 because they're hard to take over on the 3 transcript. So make sure you respond verbally. 4 Okay? 5 A. Okay. 6 Q. If any of my questions are in any way 7 unclear, will you promise to let me know so I 8 can rephrase my question and make sure you and I 9 are on the same page? 10 A. Sure. 11 Q. All right. You're the director of the 12 heart/lung transplant program here at Mayo; is 13 that right? 14 A. Yes, sir. 15 Q. Tell me a little bit about the 16 transplant program. 17 A. Well the lung transplant program has 18 been very successful in the recent years since I 19 came and we have achieve great results and we 20 have transplanted way more people than was 21 before maintaining excellent outcomes, so we're 22 kind of proud in terms of clinical experience 23 per year. We count the experience per year. 24 We're around 10th in the nation for volume. 25 Q. For lungs or hearts?</p>	<p style="text-align: right;">Page 8</p> <p>1 What are the most important survival 2 metrics to you as the director of the program 3 here? 4 A. Ninety-day survival as in the surgical 5 side, but it matters to me most what happens in 6 the long run. For example, in the last 7 scientific registry of transplant recipients we 8 have the highest survival three year of follow- 9 up in the country. 10 Q. Are you talking about for heart or 11 lung? 12 A. For heart. 13 Q. Where does -- 14 When you say "we," are you talking just 15 about Rochester, or are you talking about 16 Jacksonville, Arizona, and Rochester together? 17 A. Rochester only. 18 Q. All right. So where does Mayo 19 Rochester rank in terms of one-year survival 20 statistics for heart transplant? 21 A. Average in the nation. 22 Q. Average. 23 A. Uh-huh. 24 Q. Do you know why that is? 25 A. It's around 90 percent, 90, 92 percent</p>
<p style="text-align: right;">Page 7</p> <p>1 A. For -- for both. 2 Q. What year's statistic are you using 3 there that you're 10th in the nation in volume? 4 A. 2023, 2024. So I have managed to boost 5 the program since I arrived 2021. Before we 6 were like 40 in the nation, -- 7 Q. And there -- 8 A. -- something like that. 9 Q. I'm sorry. 10 There again you're talking about 11 volume, number of transplants. 12 A. Number of transplant and outcomes. 13 Q. So when a transplant program is being 14 evaluated, -- 15 A. Uh-huh. 16 Q. -- number of transplants is an 17 important metric and outcomes is an important 18 metric; right? 19 A. Yes, sir. 20 Q. When we're talking about outcomes, 21 we're talking about the one-year survival 22 outcomes? 23 A. That's one of the metrics. There are 24 several metrics. 25 Q. What is --</p>	<p style="text-align: right;">Page 9</p> <p>1 at a year. 2 Q. No. Sorry. 3 Do you have an idea of why Mayo is just 4 average when it comes to one-year survival? 5 A. Because we have excellent outcomes, so, 6 you know, there's half of the country that's 7 below us. 8 Q. Sure. But there's also half of the 9 country that's above you. 10 A. Yeah. But you could filter your 11 results to get them better and do low-risk 12 patients and not transplant anybody. 13 Q. So with -- 14 A. So it's excellent results, sir. 15 Q. With respect to volume, when we talk 16 about volume being an important metric, we're 17 talking getting the volume numbers up. Right? 18 A. Yeah. So that people don't die from 19 heart failure. 20 Q. Sure. Where does Mayo -- 21 You said 10th in the nation in volume? 22 A. Yes, sir. 23 Q. Just for heart. 24 A. Yes. 25 Q. And that's just --</p>

3 (Pages 6 to 9)

<p style="text-align: right;">Page 10</p> <p>1 A. Not for lung, too.</p> <p>2 Q. Let's stick just with heart. Okay?</p> <p>3 A. Okay.</p> <p>4 Q. I'm going to focus --</p> <p>5 A. I haven't say anything about lung, but</p> <p>6 you asked me.</p> <p>7 Q. I'm going to focus really specifically</p> <p>8 on heart transplant --</p> <p>9 A. Uh-huh.</p> <p>10 Q. -- for purposes of our discussions</p> <p>11 today.</p> <p>12 So your testimony is that with respect</p> <p>13 to the heart transplant program, Mayo Rochester</p> <p>14 is 10th in the nation in volume.</p> <p>15 A. Correct.</p> <p>16 Q. Where was it when you started here when</p> <p>17 you took over the program?</p> <p>18 A. Thirty, 40, somewhere in there.</p> <p>19 Q. I -- I assume that you're proud of the</p> <p>20 fact that you've increased the numbers of</p> <p>21 transplants?</p> <p>22 A. Yeah. Proud of the fact of saving</p> <p>23 lives by heart transplantation.</p> <p>24 Q. My question was: Are you proud of the</p> <p>25 fact that Mayo's volume numbers have gone up?</p>	<p style="text-align: right;">Page 12</p> <p>1 Q. Was the EXPAND trial funded by</p> <p>2 TransMedics?</p> <p>3 A. Yes.</p> <p>4 Q. Is that the only research study you've</p> <p>5 been involved in that was funded by TransMedics?</p> <p>6 A. No, I -- I --</p> <p>7 In heart -- we're talking about heart</p> <p>8 only again --</p> <p>9 Q. Yes.</p> <p>10 A. -- on this case, so in the -- then</p> <p>11 the -- the postmarket-approval registry is</p> <p>12 funded and mandated by the FDA. I'm the</p> <p>13 principal investigator here at the Mayo Clinic</p> <p>14 for that.</p> <p>15 Q. You're the principal investigator you</p> <p>16 said?</p> <p>17 A. Yes.</p> <p>18 Q. How much money does TransMedics provide</p> <p>19 to Mayo for that?</p> <p>20 A. I don't -- I don't know exactly. It's</p> <p>21 minimal enough to, you know, maintain the</p> <p>22 record.</p> <p>23 Q. More than a hundred thousand dollars?</p> <p>24 A. I don't know.</p> <p>25 Q. What other --</p>
<p style="text-align: right;">Page 11</p> <p>1 A. I answered your question. I'm proud of</p> <p>2 the fact that when we increased the volume, save</p> <p>3 heart-failure patients from death.</p> <p>4 Q. Tell me about your involvement with</p> <p>5 TransMedics.</p> <p>6 A. I -- I start using TransMedics during</p> <p>7 the clinical trials at the Massachusetts General</p> <p>8 Hospital in Boston when I was a -- an attending</p> <p>9 heart transplant surgeon at the Mass General</p> <p>10 Hospital.</p> <p>11 Q. That was your first involvement with</p> <p>12 TransMedics?</p> <p>13 A. Yes. I'm not sure 2015, maybe the end</p> <p>14 of, because I started September 2015. For sure</p> <p>15 I would say in 2016, eight years ago.</p> <p>16 Q. And so back then your involvement with</p> <p>17 TransMedics was being involved in the PROCEED</p> <p>18 trial?</p> <p>19 A. No. I was the --</p> <p>20 In the EXPAND trial. The PRO -- the</p> <p>21 PROCEED trial had already been done.</p> <p>22 Q. That's right. That was doctors mostly</p> <p>23 at UCLA?</p> <p>24 A. Yeah, UCLA, some people in Europe,</p> <p>25 Columbia.</p>	<p style="text-align: right;">Page 13</p> <p>1 You mentioned something about lung.</p> <p>2 Have you had involvement with TransMedics for</p> <p>3 lung as well?</p> <p>4 A. Yeah. I participated in the EXPAND</p> <p>5 trial. So in the case in the Mass General I was</p> <p>6 the co-investigator -- co-investigator for the</p> <p>7 EXPAND trial, but in the -- the lung side I was</p> <p>8 the principal investigator for the EXPAND</p> <p>9 trial in -- for, you know, this, you know, FDA-</p> <p>10 regulated trial.</p> <p>11 Q. And so both of those were funded</p> <p>12 exclusively by TransMedics.</p> <p>13 A. Yes.</p> <p>14 Q. Have you ever met the CEO of</p> <p>15 TransMedics?</p> <p>16 A. Yes.</p> <p>17 Q. How many times?</p> <p>18 A. Several times.</p> <p>19 Q. More than ten?</p> <p>20 A. Probably. I don't know. I don't count</p> <p>21 how many times I meet people.</p> <p>22 Q. Okay.</p> <p>23 A. Maybe 30 times.</p> <p>24 Q. Thirty times.</p> <p>25 A. Maybe. I don't know. I don't count</p>

4 (Pages 10 to 13)

<p style="text-align: right;">Page 14</p> <p>1 them. I'm guessing.</p> <p>2 Q. Have you ever traveled on a -- and had</p> <p>3 that funded in any way by TransMedics?</p> <p>4 A. Yeah. I have traveled to the</p> <p>5 investigative meetings I think twice.</p> <p>6 Q. Where were those meetings?</p> <p>7 A. One was in -- in Saint Thomas and one</p> <p>8 was in Boston, not very long travel from home.</p> <p>9 Q. TransMedics funded a meeting in Saint</p> <p>10 Thomas, the Virgin Islands?</p> <p>11 A. Yes, sir.</p> <p>12 Q. And paid for you to travel there?</p> <p>13 A. Yes.</p> <p>14 Q. Any --</p> <p>15 A. Oh, and there was one in the --</p> <p>16 So there's two, that one and there's</p> <p>17 one in -- I think they did one in the -- in</p> <p>18 Nassau, I think in Bahamas.</p> <p>19 Q. In the Bahamas.</p> <p>20 A. Uh-huh.</p> <p>21 Q. Got it.</p> <p>22 And TransMedics paid for you to go</p> <p>23 there, too.</p> <p>24 A. Yes, sir.</p> <p>25 Q. Any other ways that TransMedics has</p>	<p style="text-align: right;">Page 16</p> <p>1 Because I'm -- I didn't find it</p> <p>2 interesting and I didn't have trip days.</p> <p>3 Q. Didn't have what?</p> <p>4 A. Trip days.</p> <p>5 Q. Trip days. Got it.</p> <p>6 A. So like the time that I can get out</p> <p>7 of -- of the Mayo Clinic.</p> <p>8 Q. Yep. Got it.</p> <p>9 When TransMedics flew you to the Virgin</p> <p>10 Islands and the Bahamas, did they fly you first</p> <p>11 class or coach?</p> <p>12 A. Coach.</p> <p>13 Q. You got to fix that for the next time.</p> <p>14 Do you have stock in TransMedics?</p> <p>15 A. No.</p> <p>16 Q. Do you know -- well you --</p> <p>17 I assume you know that one of the</p> <p>18 things that the SRTR tracks is selectivity</p> <p>19 statistics.</p> <p>20 A. No.</p> <p>21 Q. Are you aware of that?</p> <p>22 A. No.</p> <p>23 Q. Okay. So then I would assume that you</p> <p>24 have no idea how Mayo Rochester matches up with</p> <p>25 other institutions in terms of selectivity.</p>
<p style="text-align: right;">Page 15</p> <p>1 provided you with any sort of financial benefit?</p> <p>2 A. No, I have not receive any consulting</p> <p>3 fees.</p> <p>4 Q. Do you have --</p> <p>5 A. Nothing other than travel and</p> <p>6 accommodation for these two meetings and the</p> <p>7 Boston one.</p> <p>8 Q. Where did you stay in Saint Thomas?</p> <p>9 A. I -- I stayed in the Ritz-Carlton in</p> <p>10 Saint Thomas.</p> <p>11 Q. How about when you went to the Bahamas</p> <p>12 on TransMedics' dime?</p> <p>13 A. What was it? Atlantis, I believe.</p> <p>14 Q. Both very nice places.</p> <p>15 A. Yeah. Been more than five years since</p> <p>16 then.</p> <p>17 Q. Sure.</p> <p>18 Any plans for TransMedics to have</p> <p>19 meetings with these new studies that are going</p> <p>20 on?</p> <p>21 A. I haven't heard any. There was --</p> <p>22 There were meetings of the</p> <p>23 investigators, I think, last year. I didn't go.</p> <p>24 Q. Why not?</p> <p>25 A. In Boston.</p>	<p style="text-align: right;">Page 17</p> <p>1 A. What do you mean by "selectivity?" I</p> <p>2 haven't heard about that term before in heart</p> <p>3 transplantation.</p> <p>4 Q. Well so, for example, one of things</p> <p>5 that SRTR tracks is offer-acceptance</p> <p>6 characteristics. Do you know that?</p> <p>7 A. Oh, yeah. Yeah.</p> <p>8 Q. Yep.</p> <p>9 A. I wouldn't call that selectivity.</p> <p>10 Q. Well so do you know what the offer-</p> <p>11 acceptance ratio refers to?</p> <p>12 A. Yeah. It was --</p> <p>13 It's better than in the nation.</p> <p>14 Q. My question was: Do you know what the</p> <p>15 offer-acceptance ratio is?</p> <p>16 A. I can't remember the number, --</p> <p>17 Q. No, no.</p> <p>18 A. -- but I just can remember our</p> <p>19 relationship to the nation, that it was better</p> <p>20 than, you know, the whole nation.</p> <p>21 Q. Well "better than," you mean that Mayo</p> <p>22 accepts a lot more organs than other</p> <p>23 institutions do?</p> <p>24 A. Yeah.</p> <p>25 Q. One of the things that I read in some</p>

5 (Pages 14 to 17)

<p style="text-align: right;">Page 18</p> <p>1 materials that were put out by Mayo is a quote 2 that says, "We say yes when others say no." 3 Have you heard that little catch phrase? 4 A. Yeah. 5 Q. Do you believe in that catch phrase? 6 A. We try to do everything that is 7 medically possibly to improve the patients' 8 lives -- 9 Q. Uh-huh. 10 A. -- and save them from death. 11 Q. Yeah. No, my question was just: Do 12 you subscribe to that little catch phrase, "We 13 say yes" -- 14 A. Well it -- it -- 15 Q. You got to -- 16 Hold on. Hold on. Doctor, you got to 17 let me finish. 18 MR. BRANTINGHAM: Yeah. Let him finish 19 the question after and then -- then you go. 20 Q. Do you subscribe to that catch phrase, 21 "When other" -- I guess it's "When others say 22 no, we say yes?" 23 A. It's a slogan. I am not in the 24 Marketing Department. 25 Q. Do you know where Mayo Rochester ranks</p>	<p style="text-align: right;">Page 20</p> <p>1 hearts with an ejection fraction below 60 as the 2 national average; right? 3 A. I don't know. I don't remember. 4 Q. Okay. If I told you that the latest 5 statistics for SRTR was that Mayo took more than 6 three times as many hearts from donors over the 7 age of 40, does that sound about right to you? 8 A. Yes, sir. 9 Q. And almost four times as many hard-to- 10 place hearts as the national average? 11 A. Yes. 12 Q. And more than double the number of 13 donors from more than 500 miles away? 14 A. Yes. 15 Q. Now in order to do that, -- 16 A. Uh-huh. 17 Q. -- you got to use the OCS; right? 18 A. Yeah. In part. 19 Q. Well you can't go get a donor heart 20 from more than 500 miles away using just 21 standard cold cardioplegia; can you? 22 A. Well it depends because, you know, 23 other centers might choose to use another 24 preservation method, SherpaPak, for example, and 25 they -- I've heard about a report that the Mass</p>
<p style="text-align: right;">Page 19</p> <p>1 in terms of the ratio of taking high-risk 2 hearts? 3 A. You mean high-risk of -- in terms of 4 the Public Health Service? 5 Q. Yes. 6 A. So in terms of risk of viral infection? 7 Q. Yes. 8 A. I -- I think it's -- I -- 9 I'm not sure. You know, I don't have 10 the report on my side here, but I think it was 11 probably twice as in the country, something like 12 that. I can't remember. Maybe you have it 13 there. 14 Q. Yeah. Two and a half times -- 15 A. Yeah. 16 Q. -- the national average in terms of -- 17 A. Yeah. 18 Q. -- taking hearts that are considered 19 high risk. 20 A. No. You are -- you are saying it 21 wrong. It's increased risk of viral 22 infections -- 23 Q. Increased risk. Got it. 24 A. -- by the Public Health Service. 25 Q. Mayo takes more than twice as many</p>	<p style="text-align: right;">Page 21</p> <p>1 General went to Alaska and got a heart from 2 Alaska with cold storage -- 3 Q. Huh. 4 A. -- with SherpaPak. 5 Q. Does Mayo use the SherpaPak? 6 A. No. It was on the shelf, but I haven't 7 used it. I used it when I was in the Mass 8 General. I wasn't the director of the program 9 at that time. 10 Q. Is there a different director of the 11 transplant program at Mayo Jacksonville? 12 A. Yes. 13 Q. And a different one at Mayo Arizona? 14 A. Yes. 15 Q. Do you know why the offer-acceptance 16 ratios at the other two Mayo institutions are so 17 much lower than Rochester's? 18 A. I don't -- 19 In general terms, they -- you know, 20 it's just -- I'll put it on the general word -- 21 probably they are more conservative. 22 Q. Do you remember the Noah Leopold case? 23 A. Yes, sir. 24 Q. Do you have like a lot of memories of 25 it or just a few?</p>

6 (Pages 18 to 21)

<p style="text-align: right;">Page 22</p> <p>1 A. I have a lot of memories.</p> <p>2 Q. Do you consider the Noah Leopold case</p> <p>3 to have been a failure?</p> <p>4 A. It's unfortunate that a patient would</p> <p>5 die.</p> <p>6 Q. That wasn't my question though.</p> <p>7 Do you consider the Noah Leopold case</p> <p>8 to have been a failure?</p> <p>9 A. I -- I think it's unfortunate a patient</p> <p>10 would have die.</p> <p>11 Q. Is --</p> <p>12 A. If you want to quote it as failure,</p> <p>13 that's you -- what you say, not what I say.</p> <p>14 Q. No. I'm asking if you agree with it</p> <p>15 though.</p> <p>16 A. Then I don't agree with it.</p> <p>17 Q. Okay. You don't agree that it was a</p> <p>18 failure.</p> <p>19 A. No.</p> <p>20 Q. Do you agree that what happened to Noah</p> <p>21 Leopold was a catastrophe?</p> <p>22 A. I don't think so.</p> <p>23 Q. No?</p> <p>24 You just think it was unfortunate.</p> <p>25 A. It was a tragedy and unfortunate.</p>	<p style="text-align: right;">Page 24</p> <p>1 A. Yeah, I -- I think the -- this</p> <p>2 gentleman here next to me, Mr. --</p> <p>3 MR. BRANTINGHAM: Brantingham.</p> <p>4 A. -- Brantingham, I don't know how to</p> <p>5 pronounce it, --</p> <p>6 MR. BRANTINGHAM: Andrew's fine.</p> <p>7 A. -- you know, show me some.</p> <p>8 Q. Okay. Did you --</p> <p>9 Have you seen the text messages that</p> <p>10 refer to either Dr. Altarabsheh or Dr. Knop</p> <p>11 telling you that the lactates for the donor</p> <p>12 heart for Noah Leopold were bad or terrible?</p> <p>13 A. No. I -- I -- I -- I don't recall</p> <p>14 that. And if they say that, it's completely</p> <p>15 wrong because the lactates were excellent.</p> <p>16 Q. No. I understand that. That wasn't my</p> <p>17 question.</p> <p>18 You know that there are a number of</p> <p>19 text messages that suggest that you asked Dr.</p> <p>20 Altarabsheh and/or Dr. Knop about the lactates</p> <p>21 and they gave you the impression that the</p> <p>22 lactates were not good; right?</p> <p>23 A. No.</p> <p>24 MR. BRANTINGHAM: Object to the form</p> <p>25 and foundation. I'm frankly not sure he is. I</p>
<p style="text-align: right;">Page 23</p> <p>1 Q. Okay. Do you remember talking with</p> <p>2 either Dr. Altarabsheh or Dr. Knop from the</p> <p>3 operating room?</p> <p>4 A. Do you mean when they were in the</p> <p>5 operating room with the donor?</p> <p>6 Q. Yeah. So let me ask it a little</p> <p>7 tighter way. There's some text messages sent in</p> <p>8 this case that --</p> <p>9 A. Uh-huh.</p> <p>10 Q. -- suggest that one --</p> <p>11 You're aware of those text messages.</p> <p>12 A. What?</p> <p>13 Q. You're nod --</p> <p>14 I started saying "text messages" and</p> <p>15 you nodded your head and said "uh-huh" like</p> <p>16 you're aware of what I'm talking about.</p> <p>17 A. No, I'm -- no, I'm --</p> <p>18 People might have sent text messages.</p> <p>19 I normally do not communicate like that.</p> <p>20 Q. Yeah.</p> <p>21 A. I'm Chilean, you know, I use very</p> <p>22 little text messaging.</p> <p>23 Q. Are you aware of the fact that there</p> <p>24 are a number of text messages that have been</p> <p>25 produced that are relevant to this case?</p>	<p style="text-align: right;">Page 25</p> <p>1 mean if you want to show him --</p> <p>2 MR. THOMPSON: Yeah, he might not be.</p> <p>3 That's fine.</p> <p>4 A. I --</p> <p>5 Q. Do you remember --</p> <p>6 A. I mean if somebody says that, it's</p> <p>7 wrong. I don't care.</p> <p>8 Q. Do you remember asking Michael Pick to</p> <p>9 go get the lactate values?</p> <p>10 A. I always ask the perfusionist the</p> <p>11 lactate values.</p> <p>12 Q. Okay. Do you remember anyone</p> <p>13 suggesting to you, before you saw the lactate</p> <p>14 values, that there was an issue with them?</p> <p>15 A. There was no one.</p> <p>16 Q. No one made such a suggestion to you.</p> <p>17 A. No. There was no bad lactic acid --</p> <p>18 Q. That wasn't my question.</p> <p>19 A. -- volume.</p> <p>20 Q. We'll talk about -- we'll talk about</p> <p>21 the lactates. I'm not asking whether there were</p> <p>22 bad lactates.</p> <p>23 I'm going to show you Mayo 25074, first</p> <p>24 of all. Do you see that top text message?</p> <p>25 Doctor, I'm asking you if you see the</p>

7 (Pages 22 to 25)

Page 26

1 top text message.

2 **A. Yeah, I see that, but I don't remember**
3 **that. But he's wrong.**

4 MR. BRANTINGHAM: Just -- yeah. So
5 wait for the question and respond --

6 Q. You got to listen to --

7 MR. BRANTINGHAM: -- specifically to
8 it.

9 **A. All right.**

10 Q. Nope. You hang onto that, because I'm
11 going to ask you some questions from it.

12 **A. Uh-huh.**

13 [REDACTED]
14 [REDACTED]
15 [REDACTED]
16 [REDACTED]
17 [REDACTED]
18 [REDACTED]
19 [REDACTED]
20 [REDACTED]
21 [REDACTED]
22 [REDACTED]
23 [REDACTED]
24 [REDACTED]
25 [REDACTED]

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1 **A. Uh-huh.**

2 Q. -- when it got to the operating room,
3 it would have been too late; right?

4 MR. BRANTINGHAM: Object to the form,
5 foundation. You can answer.

6 **A. What do you mean by "too late?"**

7 Q. By the time that donor heart got to the
8 operating room, you had already taken Noah
9 Leopold's heart out; right?

10 **A. Yeah. Because we rely on the -- on the**
11 **team that we sent to look at the heart. So --**
12 **so normally the -- the team looks at it at the**
13 **donor site, then when they are about to take off**
14 **and then when they land, so I talked to my team**
15 **in that way. And then it is the best, the**
16 **clinical practice, to start the case when the**
17 **heart is meant to look good, and then as soon as**
18 **they arrive, be ready to sew it in. So we**
19 **minimize the time on the OCS to minimize the**
20 **time of the heart out of the body.**

21 Q. How long can the heart stay viable on
22 OCS?

23 **A. We don't know for sure.**

24 Q. Do you remember giving a presentation
25 where you talked that "Most people who have" --

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1 [REDACTED]
2 [REDACTED]
3 [REDACTED]
4 [REDACTED]
5 [REDACTED]

6 Q. Do you remember anybody saying anything
7 to you about the heart not being robust --

8 **A. I don't remem --**

9 Q. -- while it was on OCS?

10 **A. I don't remember that.**

11 Q. If somebody had told you that the heart
12 did not look robust while it was on OCS, would
13 that have been noteworthy to you?

14 **A. Of course I would review that.**

15 Q. What do you mean you would review that?

16 **A. Yeah. If somebody tells me that the --**
17 **that the heart is bad, that could be wrong or**
18 **right, so I have to review it, look at it**
19 **myself.**

20 Q. You couldn't look at the heart until it
21 came to the operating room; right?

22 **A. Yeah. Could I look? No. I --**

23 **That is physically impossible.**

24 Q. If the heart had been not robust, or
25 "bad" to use your words, --

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1 there's actually a slash here -- "Most people
2 who've been involved with the OCS think that
3 total body time can be eight hours or even
4 more?"

5 **A. It's possible, but the longer you are**
6 **on the OCS, the more edema you could have on the**
7 **myocardium. So the shorter time on the OCS, the**
8 **better.**

9 Q. How long does it take for a heart to
10 get from the airport in Rochester to the
11 operating room?

12 **A. Fifteen minutes.**

13 Q. So if you had wanted to, you could have
14 waited 15 minutes to get your eyes on this heart
15 before you took out Noah's heart.

16 **A. I have trust in my team. They are**
17 **competent professionals.**

18 Q. Wasn't my question.

19 My question is if you --

20 **A. I answer it.**

21 Q. With respect, you didn't. My question
22 wasn't do you have confidence in your team.

23 **A. Yeah. But --**

24 MR. BRANTINGHAM: Let him ask the
25 question, doctor, and then you can answer.

8 (Pages 26 to 29)

<p style="text-align: right;">Page 30</p> <p>1 Q. My question was: Could you have waited 2 if you wanted to?</p> <p>3 A. Yeah. But that will be a bad clinical 4 decision because you have to shorten up the time 5 on the OCS.</p> <p>6 Q. Do you remember doing a presentation 7 with Dr. Paul Friedman from Mayo in July of 8 2023?</p> <p>9 A. Yes.</p> <p>10 Q. Do you remember that presentation?</p> <p>11 A. Yes.</p> <p>12 Q. What was it about?</p> <p>13 A. About the techniques for heart 14 transplantation, one, you know, the ex vivo 15 heart perfusion.</p> <p>16 Q. Yeah. Do you remember during that 17 presentation saying to Dr. Friedman, "So what 18 happens is, for a reason that we completely do 19 not understand, the heart gets edematous, so you 20 have to examine the heart before implanted to 21 make sure you know that it hasn't gotten that 22 edematous." Does that sound like something you 23 would have said?</p> <p>24 A. I don't remember exactly, but that 25 doesn't mean to be by me, it means to be done by</p>	<p style="text-align: right;">Page 32</p> <p>1 written by your colleagues at Mayo Jacksonville, 2 they describe the process for transplanting an 3 OCS heart. And they say, "Once the heart 4 reaches the recipient OR on the OCS machine, its 5 contractility is reassessed. Based on heart 6 function, other hemodynamic parameters, and 7 lactate levels, if it is decided to proceed with 8 the transplant, the first step is closure of the 9 aortic vent," and yadda yadda yadda. Do you 10 know whether your colleagues at Mayo 11 Jacksonville wait until the heart arrives and 12 can be reassessed in the operating room before 13 they irreversibly remove the patient's native 14 heart?</p> <p>15 MR. BRANTINGHAM: Foundation.</p> <p>16 A. I --</p> <p>17 MR. BRANTINGHAM: You can answer.</p> <p>18 A. I don't know if they wait.</p> <p>19 Q. But you told -- but you told me before 20 that it would be bad clinical practice to do 21 that. Do you think your colleagues at Mayo 22 Jacksonville are committing malpractice?</p> <p>23 A. No. I don't --</p> <p>24 MR. BRANTINGHAM: Foundation.</p> <p>25 A. -- I don't think it's --</p>
<p style="text-align: right;">Page 31</p> <p>1 the surgical team. You know, it's impossible to 2 work on -- on your own. You need to rely on 3 your surgical team, and that was done.</p> <p>4 Q. Who is Dr. Mohammad Alomari?</p> <p>5 A. Mohammad? Who's that one?</p> <p>6 Q. Do you recognize that name?</p> <p>7 A. Mohammad?</p> <p>8 Q. Yeah. One of your colleagues in 9 Jacksonville, at Mayo Jacksonville?</p> <p>10 A. I -- I don't think I know him.</p> <p>11 Q. Dr. Pankaj Garg, does that name ring a 12 bell?</p> <p>13 A. No.</p> <p>14 Q. Okay. John Yazji?</p> <p>15 A. No.</p> <p>16 Q. Dr. Wadiwala?</p> <p>17 A. No.</p> <p>18 Q. Well I'll tell you that all of those 19 guys were involved in writing an article 20 entitled "Is the Organ Care System Still the 21 First Choice With Emerging New Strategies for 22 DCD in Heart Transplant." Does that article 23 ring any bells for you?</p> <p>24 A. I -- I haven't heard about that study.</p> <p>25 Q. I will tell you that in this article,</p>	<p style="text-align: right;">Page 33</p> <p>1 MR. BRANTINGHAM: Hang on just one sec, 2 doctor. Let me -- I have to get an objection 3 out. Foundation. You can go ahead and answer.</p> <p>4 A. Well I -- I think, as I said, that the 5 longer the time on the OCS, you know, the worse 6 the results. Whether how many minutes matter or 7 not, you know, might be a matter of debate, it 8 has not been determined, so I would not accuse 9 them of malpractice. It is -- is they might 10 have a different approach, but it's not proven 11 that it's better or worse.</p> <p>12 Q. Well didn't you tell me, when I asked 13 you if you could have waited that 15 minutes, 14 "Yes, I could have, but it would be bad clinical 15 practice?"</p> <p>16 A. Yeah, yeah. From my standpoint, I 17 said, you know -- again, I'm going to repeat to 18 you, maybe you're not listening -- the longer -- 19 that the longer that you are on the OCS, the 20 more edema you get. So it is, for me, 21 preferable to, you know, be ready to sew the 22 heart in once it arrives. And provided that you 23 have trust on your surgical team, which I do.</p> <p>24 Q. Let's go back to my question, though, 25 because that wasn't my question.</p>

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1 My question was: Didn't you tell me
2 under oath a few minutes ago, when I asked
3 you --
4 **A. Uh-huh.**
5 Q. -- if you could have waited, you said,
6 "Yes, I could, but that would be bad clinical
7 practice?"
8 MR. BRANTINGHAM: Let me just object --
9 object that I think that is quite explicitly
10 reasking the exact same question you think you
11 already asked, so asked and answered.
12 MR. THOMPSON: He didn't answer it.
13 Q. But go ahead.
14 MR. BRANTINGHAM: Go ahead.
15 **A. Well I -- I think I would -- I would**
16 **not do that because that would result in -- in a**
17 **worse clinical result.**
18 Q. Okay. Did you tell me that waiting
19 would be bad clinical practice?
20 MR. BRANTINGHAM: I mean we can read
21 back the transcript, but it's -- it's been asked
22 and answered. Maybe one more time, go ahead and
23 answer.
24 **A. I would prefer not to wait to decrease**
25 **the -- the edema on the heart.**

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1 Q. Wasn't my question. I didn't ask you
2 if you preferred to wait. I asked you if you
3 remember telling me under oath that waiting
4 would be bad clinical practice.
5 **A. Well you are -- you are trying to bring**
6 **up a controversy with my colleagues in Mayo**
7 **Florida. I don't think that's appropriate.**
8 **Maybe my words were not exactly right, but I**
9 **think it's preferable to not let the heart get**
10 **more edematous and to decrease the time on the**
11 **OCS.**
12 Q. Okay. So now you'd like to retract
13 what you said earlier that it was bad clinical
14 practice?
15 **A. Well in -- in the terms that -- your**
16 **legal terms maybe; in my -- in my clinical**
17 **positive way probably is appropriate. But you**
18 **understand one thing, I understand a different**
19 **one because we have different backgrounds.**
20 Q. I'm asking you for your own words,
21 doctor. Do you think it would be bad clinical
22 practice to wait or don't you?
23 **A. I would not accuse a colleague of bad**
24 **clinical practice.**
25 Q. I wasn't asking you if you accused a

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1 colleague of anything.
2 **A. Well that's what you're implying, so I**
3 **am answering your question.**
4 Q. Don't try to read into my implication.
5 Just answer the question I'm asking.
6 **A. I -- I answer it.**
7 Q. No, you didn't.
8 MR. BRANTINGHAM: Hold on one sec,
9 doctor. Should we read back the original answer
10 so that we have clarity on --
11 MR. THOMPSON: No, because now he's
12 going to --
13 MR. BRANTINGHAM: -- what was said?
14 MR. THOMPSON: -- because now he put --
15 I'm good. Do you have an objection?
16 MR. BRANTINGHAM: My objection I think
17 is asked and answered.
18 MR. THOMPSON: Great. Thank you.
19 MR. BRANTINGHAM: Okay.
20 Q. Is it bad clinical practice to wait or
21 isn't it?
22 MR. BRANTINGHAM: You can answer that
23 question.
24 **A. I -- I think it would produce more**
25 **edema on the heart, so I would not do that.**

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1 Q. That wasn't my question.
2 **A. I answer your question.**
3 Q. No, you didn't. You answered a
4 different question that I didn't ask, and we're
5 going to keep asking this question until you
6 actually answer it.
7 **A. Then I think it's not a --**
8 **Then I don't think so.**
9 Q. You don't think it's bad clinical
10 practice.
11 **A. In legal terms, no.**
12 Q. Okay. You just think it's not
13 something you would do.
14 **A. Yeah. I would not do clinically**
15 **because I want the best result for my patient.**
16 Q. And you think that doing that, waiting,
17 can lead to worse clinical outcomes.
18 **A. Yes.**
19 Q. Are you going to call up your
20 colleagues in Jacksonville and tell them, "Hey
21 guys, what you're doing may lead to bad clinical
22 outcomes, and since we care about saving
23 patients' lives here at the Mayo Clinic, maybe
24 you should think about doing it differently?"
25 MR. BRANTINGHAM: Object to the form of

10 (Pages 34 to 37)

<p style="text-align: right;">Page 38</p> <p>1 the question and the foundation. You can</p> <p>2 answer.</p> <p>3 A. This --</p> <p>4 To say that, you know, I will have</p> <p>5 to -- I need to have a -- a study about the</p> <p>6 times on the OCS, and we don't have that so far</p> <p>7 in the literature.</p> <p>8 Q. None of that was my question.</p> <p>9 You told me that in your opinion, as</p> <p>10 the director of the heart/lung transplant</p> <p>11 program at Mayo Clinic Rochester, waiting until</p> <p>12 the heart arrives in the operating room before</p> <p>13 you explant the native heart leads to worse</p> <p>14 clinical outcomes. My question is: Are you</p> <p>15 going to contact your colleagues at Mayo</p> <p>16 Jacksonville and tell them, "Hey guys, what</p> <p>17 you're doing may lead to worse clinical</p> <p>18 outcomes?"</p> <p>19 MR. BRANTINGHAM: Object to the form.</p> <p>20 You can answer.</p> <p>21 A. I will not do that until there is a</p> <p>22 study that would, you know, resolve that</p> <p>23 question.</p> <p>24 Q. Do you remember what this heart looked</p> <p>25 like when it came out of the box?</p>	<p style="text-align: right;">Page 40</p> <p>1 fine.</p> <p>2 Q. How big of a size mismatch was there?</p> <p>3 A. Thirty-percent different.</p> <p>4 Q. And in your clinical view that is</p> <p>5 significant; right?</p> <p>6 A. Well it's --</p> <p>7 I have transplanted many hearts that</p> <p>8 have been larger than 30 percent successfully.</p> <p>9 Q. My question was: Is a 30-percent size</p> <p>10 mismatch, in your clinical view, significant?</p> <p>11 A. Yeah, it's significant.</p> <p>12 Q. Did you think going into this surgery</p> <p>13 there was going to be a 30-percent size</p> <p>14 mismatch?</p> <p>15 A. Yeah, because the -- the donor was</p> <p>16 larger, and that's good for the hemodynamics of</p> <p>17 the recipients. So the larger the size is, the</p> <p>18 hemodynamics are better after a heart</p> <p>19 transplantation.</p> <p>20 Q. Do you remember talking with members of</p> <p>21 the Leopold family after this catastrophic</p> <p>22 failed transplant?</p> <p>23 A. I -- I remember --</p> <p>24 MR. BRANTINGHAM: Object to the form of</p> <p>25 the question. Go ahead, you can answer, doctor.</p>
<p style="text-align: right;">Page 39</p> <p>1 A. Yes.</p> <p>2 Q. What did it look like?</p> <p>3 A. Excellent function.</p> <p>4 Q. What color was it?</p> <p>5 A. Like the color of a heart, like yellow</p> <p>6 and red.</p> <p>7 Q. Any oth --</p> <p>8 Anything else you can describe for me?</p> <p>9 A. There was some ecchymosis, you know, on</p> <p>10 the heart, that's meaning a little bit of</p> <p>11 bruising.</p> <p>12 Q. Anything else you can describe for me?</p> <p>13 A. The squeezing function was excellent.</p> <p>14 Q. Did you notice, when the heart came out</p> <p>15 of the box, that it was larger than expected?</p> <p>16 A. No, it was not larger than expected.</p> <p>17 Q. When you tried to transplant it into</p> <p>18 Noah there was a significant size mismatch; was</p> <p>19 there not?</p> <p>20 A. Yeah, that's -- there was a size</p> <p>21 mismatch. That doesn't -- it's not the same</p> <p>22 that -- larger than expected. It was a size</p> <p>23 mismatch, so because I'm a transplant surgeon, I</p> <p>24 made the surgical maneuvers to fix that, and</p> <p>25 those maneuvers were successful, and so it was</p>	<p style="text-align: right;">Page 41</p> <p>1 A. I -- I remember talking to them.</p> <p>2 Q. Do you remember telling them that you</p> <p>3 knew right away that the heart was bruised and</p> <p>4 didn't look great, but by then it was too late?</p> <p>5 A. Well it was -- was -- you know, had</p> <p>6 bleeding several hours after it was implanted.</p> <p>7 It was bruised at the beginning, but just as</p> <p>8 described in the operative note, it is mildly</p> <p>9 bruised as is in the usual OCS cases.</p> <p>10 Q. Mr. Leopold's family is going to</p> <p>11 testify that you told them that you knew right</p> <p>12 away when that heart came out of the box that it</p> <p>13 was bruised and it didn't look great, but by</p> <p>14 then it was too late because Noah's native heart</p> <p>15 had already been explanted. If -- you got to</p> <p>16 let me ask my question -- if they testify that</p> <p>17 you told them that, are you going to deny it?</p> <p>18 A. I -- I --</p> <p>19 In terms of the timing, I'm going to</p> <p>20 deny it. Because what had happened is it was,</p> <p>21 you know, severely bruised. If you -- you know,</p> <p>22 this is a qual -- qualitative description, you</p> <p>23 know, more like a hematoma, so big-time</p> <p>24 bruising. That -- that's what I told them that,</p> <p>25 you know, happened several hours later as, you</p>

11 (Pages 38 to 41)

<p style="text-align: right;">Page 42</p> <p>1 know, the transplant went through. But -- but 2 the bruising was mild. 3 Q. And you're sticking right now with you 4 thought the heart itself looked excellent when 5 it first came out of the box. 6 A. Yes. 7 Q. When you accepted this heart for 8 transplant, did you know about the donor's 9 social and health history? 10 A. Yes. 11 Q. Did you know that the donor was a meth 12 addict? 13 A. Yes, sir. 14 Q. Did you know that the donor had died of 15 a meth overdose? 16 A. Yes. 17 Q. Did you know that the donor had died of 18 an intracranial hemorrhage that was brought on 19 by that meth overdose? 20 A. Yes. 21 Q. You know that heart transplant 22 recipients of donors with intracranial 23 hemorrhage have worse survival; right? 24 A. That has not been established clearly 25 in the literature.</p>	<p style="text-align: right;">Page 44</p> <p>1 matched in risk factors, so the difference could 2 have been different risk factors. For example, 3 the group with intracranial hemorrhage were 4 older, so that could have been the reason of the 5 one-percent difference. 6 Q. None of that was my question. 7 When you published that abstract with 8 the title "Heart Transplant Recipients of Donors 9 with Intracranial Hemorrhage Have Worse 10 Survival," did you intend to say "Heart 11 Transplant Recipients of Donors with 12 Intracranial Hemorrhage Have Worse Survival, But 13 It's Not Clinically Significant?" 14 MR. BRANTINGHAM: I just object to the 15 form of the question. Go ahead. 16 A. The -- 17 I was not the first nor the last 18 author. So I -- I -- 19 In terms that this was submitted to a 20 meeting, I thought it was reasonable, but it's 21 not something that could be accepted in regular 22 clinical practice because that will leave many, 23 many patients with no life-saving heart 24 transplant. 25 Q. None of that was my question either.</p>
<p style="text-align: right;">Page 43</p> <p>1 Q. You wrote an article that literally has 2 that as the title; right? 3 A. Yeah. But the title is one thing, and 4 the other thing is how it -- how it looks like. 5 Q. How what looks like? 6 A. Because if you read -- 7 I'm going to explain the -- the 8 abstract. The abstract shows that in the United 9 States over 6,000 patients have been 10 transplanted with intracranial hemorrhage, so 11 kind of two years' worth of heart transplant 12 practice in the whole United States. So that 13 obviously -- it should tell you that taking 14 donors with intracranial hemorrhage is a 15 standard practice. And if you -- 6,000 heart 16 transplants. And then if you see the abstract 17 with an academic eye, you will see the 18 difference that was encountered was a 19 one-percent difference, between, you know, 20 11.9 -- so 12 percent and 13-point-something 21 percent, one percent difference. Not clinically 22 significant, just the study signify significant. 23 And one more issue with that is that when 24 there's a comparison of intracranial hemorrhage 25 versus other type of strokes, the groups are not</p>	<p style="text-align: right;">Page 45</p> <p>1 Let me try again. I'll try a different 2 question. 3 With respect to the clinical 4 significance of these findings, do you remember 5 what the conclusion is in this abstract? 6 A. That -- that you need to be cautious 7 with intracranial-hemorrhage donors. 8 Q. And matched carefully with the 9 appropriate recipient; right? 10 A. And -- 11 Yeah. 12 Q. Got it. 13 Were you involved in any 14 informed-consent discussions with Mr. Leopold 15 before this surgery? 16 A. Yes. 17 Q. When did you meet with him? 18 A. The day before the transplant. 19 Q. The day before the transplant? 20 A. Well I mean during the day. You know, 21 the transplant was during the night, so that's 22 what I mean, the day. 23 Q. Got it. 24 A. Actually I think it was -- you know, 25 the transplant was in the night, so in -- in</p>

12 (Pages 42 to 45)

<p style="text-align: right;">Page 46</p> <p>1 that. There's two days in "during the night," 2 so in the -- that day of that night, the 3 previous day of that night I talked to him and 4 the family. 5 Q. Do you remember about what time that 6 was? 7 A. Maybe 3:00 p.m. Maybe. I can't 8 remember. 9 Q. Do you remember -- do you remember 10 anything about the conversation? 11 A. I remember there was a kind of half-an- 12 hour conversation and that they -- all their 13 questions were answered. 14 Q. Did Noah have lots of questions? 15 A. Yes. 16 Q. Like what? 17 A. I don't remember. 18 Q. You don't remember a single one? 19 A. Like "How is the donor?" "It's a good 20 donor." 21 Q. He asked "How's the donor?" and you 22 said "It's a good donor?" 23 A. "It's a good donor." 24 Q. When he asked "How's the donor?" and 25 you said, "Oh, it's a good donor," --</p>	<p style="text-align: right;">Page 48</p> <p>1 the benefits and the risks of the organ that 2 you're planning on implanting in his body? 3 A. We talked before the patient is listed, 4 so we got a -- a surgical consult either by me 5 or one of my heart transplant colleagues. And 6 as -- and as I said, you know, I talked to the 7 recipient, you know, before the transplant, as I 8 said I did. 9 Q. Okay. None of that's my question. 10 My question is: When you had the 11 conversation with Noah, did you talk with him 12 about the benefits and risks, not of the overall 13 procedure, but of the specific organ you were 14 planning on implanting in his body? 15 A. Well they have already been consulted 16 by the whole team about that for extensive and 17 overwhelming period of time. So we normally 18 would tell -- you know, ask if there are any 19 further questions of what has been already 20 discussed, because the patient had had many 21 discussions with the cardiologist, with another 22 heart surgeon and so on and so forth, so we, you 23 know, don't want to be redundant, and then, you 24 know, ask if there's anything new. 25 Q. Okay.</p>
<p style="text-align: right;">Page 47</p> <p>1 A. Yeah. 2 Q. -- did he ask you any follow-up 3 questions on that? 4 A. I don't remember. 5 Q. When he asked you "How is the donor?" 6 and you said "Good donor," did you tell him "But 7 we've got to consider this donor with caution 8 because he had an intracranial hemorrhage?" 9 A. It is -- it is forbidden by UNOS 10 policies to give healthcare information or 11 mechanism of death -- 12 Q. Right. 13 A. -- to the donor, so we would not 14 discuss that. 15 Q. Okay. So what is your understanding of 16 what your obligation is when you're providing 17 informed consent? 18 A. It is to tell the patient about the 19 procedure they are going to have. 20 Q. Is that it? 21 A. Yeah. The benefits and the risks. 22 Q. Benefits and the risks of what? 23 A. Of the procedure, meaning heart 24 transplantation. 25 Q. Do you talk with them in the -- about</p>	<p style="text-align: right;">Page 49</p> <p>1 A. In general terms. You know, I can't 2 remember what I talked to him and the family, I 3 just remember that it was a half an hour. 4 Q. This -- 5 Discussions that he had had in the days 6 and weeks prior to the discussion you had with 7 him, nobody knew anything about the donor heart 8 that was going to be implanted in him then; 9 right? 10 A. Do you think we have a crystal ball or 11 something about how the donor's going to be? 12 Q. Well that's exactly my point. You 13 don't have a crystal ball, so you -- 14 A. Yeah. 15 Q. -- nobody at Mayo would have been able 16 to tell Noah anything about the risks and 17 benefits of that specific organ until the 18 morning of August 29th; right? 19 A. No. We could not tell the specific, as 20 I -- as we said, because, you know, UNOS forbids 21 that. 22 Q. UNOS doesn't forbid that and neither 23 does the OPTN. 24 A. It's the same thing. 25 Q. Yeah.</p>

13 (Pages 46 to 49)

<p style="text-align: right;">Page 50</p> <p>1 MR. BRANTINGHAM: Just hold on --</p> <p>2 wait --</p> <p>3 A. No, no. It does. It does.</p> <p>4 Q. Is it --</p> <p>5 A. It does forbid that.</p> <p>6 MR. BRANTINGHAM: Hold on. Hold on.</p> <p>7 Hold on. Wait for a question.</p> <p>8 Q. I'm going to ask a question.</p> <p>9 MR. BRANTINGHAM: Wait for a question.</p> <p>10 Q. The question --</p> <p>11 So what is your basis for saying that</p> <p>12 you are forbidden from telling somebody that the</p> <p>13 donor died of an intracranial hemorrhage?</p> <p>14 A. Because there's UNOS, you know, bylaws</p> <p>15 and then you cannot do that.</p> <p>16 Q. Are you talking about the OPTN Guidance</p> <p>17 on --</p> <p>18 A. On UNOS.</p> <p>19 Q. Huh?</p> <p>20 A. On UNOS.</p> <p>21 Q. UNOS or OPTN?</p> <p>22 A. Well it's the same thing.</p> <p>23 Q. They're two different organizations;</p> <p>24 aren't they?</p> <p>25 A. Well they overlap.</p>	<p style="text-align: right;">Page 52</p> <p>1 overlap.</p> <p>2 Q. Have you ever seen OPTN's Guidance for</p> <p>3 Donor and Recipient Information Sharing?</p> <p>4 A. Yeah, I think I saw that.</p> <p>5 Q. The guidance that --</p> <p>6 Do you know what OPTN is?</p> <p>7 A. Organ Procurement Transplantation</p> <p>8 Network.</p> <p>9 Q. How do they relate to your practice?</p> <p>10 A. So they establish kind of the framework</p> <p>11 of the practice, transplant practice.</p> <p>12 Q. What OPTN says is that "Deceased donor</p> <p>13 information routinely shared with the</p> <p>14 recipients/recipient families should be limited</p> <p>15 to information required as part of the recipient</p> <p>16 informed consent process for transplantation."</p> <p>17 What part of that says you can't tell them that</p> <p>18 they died of an intracranial hemorrhage?</p> <p>19 MR. BRANTINGHAM: I just object to form</p> <p>20 and note for the record the pat -- the witness</p> <p>21 is not being shown the document that is being</p> <p>22 read to him.</p> <p>23 Q. I just read you the statement. What</p> <p>24 part of that --</p> <p>25 A. No -- no --</p>
<p style="text-align: right;">Page 51</p> <p>1 Q. How so?</p> <p>2 A. Because they take care of a heart</p> <p>3 tran -- I mean transplantation in the U.S.</p> <p>4 Q. Well sure, so does LifeSource. Is</p> <p>5 LifeSource and the OPTN the same thing?</p> <p>6 A. Yeah. So, no, they overlap.</p> <p>7 Q. Wasn't my question. You keep telling</p> <p>8 me that UNOS and OPTN are the same thing.</p> <p>9 A. Well --</p> <p>10 MR. BRANTINGHAM: Hold -- just wait --</p> <p>11 wait -- wait for him to get to an actual --</p> <p>12 Q. You got to wait for the question.</p> <p>13 MR. BRANTINGHAM: There's a lot of</p> <p>14 words before an actual question. Let all the</p> <p>15 words come, --</p> <p>16 THE WITNESS: Okay.</p> <p>17 MR. BRANTINGHAM: -- and then when</p> <p>18 there's a real question, answer that question.</p> <p>19 THE WITNESS: Okay.</p> <p>20 BY MR. THOMPSON:</p> <p>21 Q. Is it really your testimony that OPTN</p> <p>22 and UNOS are the same thing?</p> <p>23 MR. BRANTINGHAM: Object to form. Go</p> <p>24 ahead, doctor, you can answer.</p> <p>25 A. Honestly, I'm not sure. They usually</p>	<p style="text-align: right;">Page 53</p> <p>1 Q. -- says you can't tell them there's an</p> <p>2 intracranial hemorrhage?</p> <p>3 A. I don't know the exact document that</p> <p>4 you have, but I've read that they can't be</p> <p>5 informed about the cause of death.</p> <p>6 Q. You read that somewhere.</p> <p>7 A. Yes.</p> <p>8 Q. That you're prohibited from doing that.</p> <p>9 A. Yes, sir.</p> <p>10 Q. Do you have an understanding that what</p> <p>11 Minnesota law requires, when you're providing</p> <p>12 informed consent to a patient, is you have to</p> <p>13 give the patient all of the information that a</p> <p>14 reasonable patient in that person's position</p> <p>15 would find significant in making a decision</p> <p>16 about their own healthcare?</p> <p>17 A. I don't know about that. I'm not a</p> <p>18 lawyer.</p> <p>19 Q. Do you strive, when you are providing</p> <p>20 informed consent to patients, to give a patient</p> <p>21 all the information they would find significant?</p> <p>22 A. Yes, we do that in the -- in the</p> <p>23 consult, official consult, surgical now before</p> <p>24 the patient is listed, --</p> <p>25 Q. I'm --</p>

14 (Pages 50 to 53)

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1 **A. -- as Dr. Daly did.**

2 Q. Yep. I'm sticking with your
3 conversation. When you provided informed
4 consent to Noah --

5 When Dr. Daly talked to Noah, Dr. Daly
6 didn't know that this donor organ was going to
7 be coming from a meth addict who died of an
8 intracranial hemorrhage; right?

9 **A. Yep. We -- we should not tell the**
10 **patient that.**

11 Q. Wasn't my question.

12 My question was: When Dr. Daly talked
13 to Mr. Leopold, Dr. Daly didn't know that the
14 heart was coming from a meth addict who died of
15 an intracranial hemorrhage; did he?

16 **A. Well he didn't know, --**

17 Q. Did he --

18 **A. -- but he knew that 20 or 30 percent of**
19 **the donors are -- in the U.S. are from drug**
20 **overdose, so we discuss that.**

21 Q. "We" being who?

22 **A. We, any transplant professional, you**
23 **know, would know that 20 or 30 percent are**
24 **from -- from a drug addict in the U.S. from drug**
25 **overdose.**

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1 Q. Which means that 70 or 80 percent of
2 them do not come from a drug overdose; right?

3 **A. Yes.**

4 Q. Which means that, assuming that Dr.
5 Daly had that discussion with Noah, Noah would
6 have understood that there was a seven- or
7 eight-out-of-ten chance that the donor for his
8 heart would not have had a drug overdose; right?

9 **A. Yeah, that is possible; however, the --**
10 **he was told about this was an increased-risk**
11 **donor. And increased-risk donor, Mr. Leopold**
12 **knew very clearly that it could be, you know, a**
13 **drug addict, and -- and he consented for that**
14 **and that's documented.**

15 Q. Okay. So first of all, please listen
16 to my question and just answer my question. My
17 question didn't have anything to do with any of
18 that.

19 **A. Well I'm not going to answer what you**
20 **want.**

21 Q. Well you've got to answer my questions
22 though.

23 **A. Yeah. I did.**

24 MR. BRANTINGHAM: Hold on, doctor.

25 Q. Just hang on. Hang on. Hang on.

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1 MR. BRANTINGHAM: Let him -- wait for
2 the next question.

3 Q. Hang on. I know that you're a busy
4 man. I know that you don't want to be here. I
5 get that. I would like to go home to
6 Minneapolis as well. This will go a lot more
7 smoothly if you answer the questions that I'm
8 asking. Just answer that question, then stop,
9 let me ask another question rather than
10 answering my question and then trying to read
11 into where I'm trying to go with it and give me
12 a bunch of other information that has nothing to
13 do with the question that I asked. So --

14 **A. I think the situation is different. I**
15 **think the situation is that you don't like my**
16 **answers, and I -- you have to accept my answers.**
17 **You know, I'm a medical professional.**

18 Q. Okay. Fair -- I --

19 It's on the record now that I'm trying
20 really hard to get through this, and if we got
21 to be here all night, we'll be here all night.

22 I've got seven and a half hours with you, so --

23 Let's go back to my question. When Dr.
24 Daly talked to Noah, he didn't know that the
25 heart that was going to be implanted into Noah's

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1 chest was coming from a meth addict who had an
2 intracranial hemorrhage; isn't that true?

3 **A. No, he didn't --**

4 **Yeah. He didn't know.**

5 Q. The only surgeon who provided informed
6 consent to Noah after that information became
7 available was you; isn't that true?

8 **A. The con --**

9 **The informed consent is -- is done**
10 **previously --**

11 Q. Uh-huh.

12 **A. -- in the surgical note. It's a --**
13 **it's a team approach.**

14 Q. Wasn't my question. We'll go back to
15 my question.

16 The only surgeon who provided informed
17 consent to Noah after the information about the
18 donor became available was you; isn't that true?

19 **A. The surgeon --**

20 **Yeah. Uh-huh.**

21 Q. So let's stick specifically with what
22 you told Noah. You told him it was a good
23 donor, --

24 **A. Uh-huh.**

25 Q. -- and then you talked with him about

15 (Pages 54 to 57)

Page 58

1 the risks and benefits just of the transplant
 2 procedure, but not the risks and benefits of the
 3 donor organ. Do I have that right?
 4 **A. No.**
 5 Q. What part do I have wrong?
 6 **A. Because how the transplant procedure**
 7 **could be separated from the donor procedure.**
 8 Q. Okay. Then tell me with as much
 9 specificity as you can what you told Noah about
 10 the potential risks of this specific donor
 11 organ.
 12 **A. I -- I thought it -- and -- it was**
 13 **an --**
 14 **That it was an excellent donor and that**
 15 **normally -- I can't recall exactly what -- what**
 16 **was the conversation, as I said before -- but,**
 17 **you know, the -- the risk of cardiac surgery,**
 18 **you know, was done. Risks of cardiac surgery**
 19 **are stroke, bleeding, wound infection, renal**
 20 **failure, the whole medicine is a risk. That's**
 21 **the risk.**
 22 Q. None of that answered my question at
 23 all. I asked you what specifically did you tell
 24 Noah about the risks of this specific donor
 25 organ.

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1 **A. Again -- again, I already told you that**
 2 **we don't talk in specifics because that's**
 3 **banned, --**
 4 Q. So --
 5 **A. -- is -- is confidential information**
 6 **about the donor.**
 7 Q. So what you told him was this was an
 8 excellent donor and that's it.
 9 **A. Yeah. And if they had any question --**
 10 **and I don't recall what other question they**
 11 **have, but I remember that I stayed there**
 12 **answering question for half an hour.**
 13 Q. Okay. Let's, again, stick just with
 14 the donor organ. Am I correct that the only
 15 information you gave Noah Leopold about this
 16 donor organ was it's coming from an excellent
 17 donor?
 18 **A. I don't recall the -- the conversation**
 19 **entirely. I know that the donor told her -- I**
 20 **mean that our transplant coordinator told her**
 21 **that it was from increased-risk donor, and he**
 22 **accepted that.**
 23 Q. I'm not talking about what the
 24 transplant coordinator talked with him about.
 25 I'm not talking about what anybody else talked


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1 with him about. We're sticking with you. So --
 2 **A. Yeah. That's what --**
 3 Q. Hold on. Hold on.
 4 **A. But let -- but let me -- you -- you**
 5 **are --**
 6 MR. BRANTINGHAM: Wait for --
 7 **A. You allude to me, so I need to answer.**
 8 **Because we are part of the team that**
 9 **informs things to the -- to the -- to the**
 10 **recipient, so I rely in my colleagues, my**
 11 **cardiology, my transplant coordinator to give**
 12 **the most information that we can to the patient.**
 13 **And I went there and spent a half an hour at**
 14 **least talking to them and doing the best job**
 15 **that we can.**
 16 Q. Great. Now I've talked to Dr.
 17 Rosenbaum and I'll probably talk to the
 18 transplant coordinator. What I'm interested in
 19 right now, though, is talking to you about what
 20 you told Mr. Leopold, so I'm going to go back to
 21 my question.
 22 When you spent that half hour talking
 23 to Noah Leopold, did you tell him anything about
 24 the risks of this donor organ other than just
 25 saying "This is an excellent donor?"

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1 **A. I don't recall, but I --**
 2 **I don't recall any more than that, but**
 3 **it was an excellent donor and continues to be.**
 4 Q. Would it be your standard practice to
 5 tell a person like Noah anything about the risks
 6 of the donor organ other than "You know what,
 7 this is an excellent donor?"
 8 **A. Well the standard practice is we have**
 9 **to talk about DCD, if it's DCD or not DCD. This**
 10 **donor was not DCD, it was brain dead. Whether**
 11 **or not, you know, it's increased risk, all**
 12 **right, it's already done by the transplant**
 13 **coordinator and we have to -- and -- and if he**
 14 **was hepatitis C or not hepatitis C. This donor**
 15 **was not hepatitis C positive, so that's --**
 16 **that's why, you know, we have to make sure that**
 17 **we provide that information, and we did.**
 18 Q. Okay. Back to my question.
 19 Would it have been your standard
 20 practice --
 21 I know you don't remember this
 22 conversation, but you know this wasn't a DCD
 23 donor; right?
 24 **A. (Witness nodding.)**
 25 Q. Yes? You've got to say yes for the

16 (Pages 58 to 61)

<p style="text-align: right;">Page 62</p> <p>1 record.</p> <p>2 A. Yeah, it was not.</p> <p>3 Q. And you know that this wasn't a --</p> <p>4 A. And I already told you that already, --</p> <p>5 Q. You know this --</p> <p>6 A. -- so it's already on the transcript.</p> <p>7 Q. You know that this wasn't a hepatitis C</p> <p>8 donor; right?</p> <p>9 A. Yes.</p> <p>10 Q. So let's stick with this donor, not</p> <p>11 some other hypothetical donor. Let's stick with</p> <p>12 this donor.</p> <p>13 A. Well I stick to this donor because, you</p> <p>14 know, as I said --</p> <p>15 MR. BRANTINGHAM: Let him get to the</p> <p>16 next question, doctor.</p> <p>17 A. Yeah. But you are -- you are repeating</p> <p>18 the information.</p> <p>19 Q. Are you ready for me to ask a question?</p> <p>20 A. Yes, sir. Go ahead.</p> <p>21 Q. With respect to this specific donor, in</p> <p>22 your general practice, the way that you</p> <p>23 typically do things, would you have told Noah</p> <p>24 anything about the donor organ other than it's</p> <p>25 coming from an excellent donor?</p>	<p style="text-align: right;">Page 64</p> <p>1 THE REPORTER: Okay. Off the record.</p> <p>2 (Recess taken from 2:16 p.m. to 2:21</p> <p>3 p.m.)</p> <p>4 THE VIDEOGRAPHER: We're on video.</p> <p>5 THE REPORTER: We're on the record.</p> <p>6 BY MR. THOMPSON:</p> <p>7 Q. Did you look at your operative report</p> <p>8 as part of preparing to give your deposition</p> <p>9 today, doctor?</p> <p>10 A. Yes, sir.</p> <p>11 Q. When is the last time you looked at</p> <p>12 your operative report?</p> <p>13 A. This morning.</p> <p>14 Q. All right. Do you remember which of</p> <p>15 the two procurement surgeons called you to talk</p> <p>16 with you about the assessment of the heart when</p> <p>17 they were still in Idaho?</p> <p>18 A. I don't.</p> <p>19 Q. Do you know for a fact that one of them</p> <p>20 called you?</p> <p>21 A. I don't. I don't know. I trust both.</p> <p>22 Q. When you say you trust them, you trust</p> <p>23 their assessment?</p> <p>24 A. Yes.</p> <p>25 Q. Do you feel confident that they can</p>
<p style="text-align: right;">Page 63</p> <p>1 A. I have to respond again? The only</p> <p>2 thing that I would have told him about, DCD,</p> <p>3 hepatitis C, and increased-risk donor, and</p> <p>4 whether it was something controversial or not.</p> <p>5 There wasn't any controversial in the donor.</p> <p>6 Q. So again, like let's not talk about</p> <p>7 some hypothetical donor that this wasn't. You</p> <p>8 told --</p> <p>9 A. No, I -- I tell you.</p> <p>10 Q. Okay. We're going to keep at this</p> <p>11 until we get straightforward answers to my</p> <p>12 straightforward questions. We're going to go</p> <p>13 back again.</p> <p>14 With respect to this specific donor, if</p> <p>15 you were following your standard practice, would</p> <p>16 you have told Noah anything about the donor</p> <p>17 organ other than it's coming from an excellent</p> <p>18 donor?</p> <p>19 A. Well in -- in this case, I wouldn't</p> <p>20 have told anything because all the evidence was</p> <p>21 excellent.</p> <p>22 Q. Let's talk about the surgery itself.</p> <p>23 MR. BRANTINGHAM: We're about an hour</p> <p>24 in. Maybe take five?</p> <p>25 MR. THOMPSON: Sure.</p>	<p style="text-align: right;">Page 65</p> <p>1 independently decide that a heart is suitable</p> <p>2 for transplantation?</p> <p>3 A. That's the normal clinical practice all</p> <p>4 over the world.</p> <p>5 Q. Is the normal clinical practice at Mayo</p> <p>6 for them to call you and walk you through what</p> <p>7 they're seeing, or is it for them to just make</p> <p>8 the decision that this looks good?</p> <p>9 A. No, it's mandatory a phone call.</p> <p>10 Q. Okay. How long does the phone call</p> <p>11 usually last?</p> <p>12 A. Five minutes.</p> <p>13 Q. What sorts of information do they</p> <p>14 generally provide you?</p> <p>15 A. If there's any contraindication in the</p> <p>16 donor; for example, if they see a tumor, for</p> <p>17 example. They want to see how the function of</p> <p>18 the heart, what are the hemodynamics, if -- if</p> <p>19 they palpate any coronary disease, verify</p> <p>20 everything that is in the computer, you know, in</p> <p>21 the computer -- in the donor that -- there's</p> <p>22 some information, but you have to verify it</p> <p>23 onsite. That's the normal way.</p> <p>24 </p> <p>25</p>

17 (Pages 62 to 65)

<p>Page 66</p> <p>1 [REDACTED]</p> <p>2 [REDACTED]</p> <p>3 [REDACTED]</p> <p>4 [REDACTED]</p> <p>5 [REDACTED]</p> <p>6 [REDACTED]</p> <p>7 [REDACTED]</p> <p>8 [REDACTED]</p> <p>9 [REDACTED]</p> <p>10 [REDACTED]</p> <p>11 [REDACTED]</p> <p>12 [REDACTED]</p> <p>13 [REDACTED]</p> <p>14 [REDACTED]</p> <p>15 [REDACTED]</p> <p>16 [REDACTED]</p> <p>17 [REDACTED]</p> <p>18 [REDACTED]</p> <p>19 [REDACTED]</p> <p>20 [REDACTED]</p> <p>21 [REDACTED]</p> <p>22 [REDACTED]</p> <p>23 [REDACTED]</p> <p>24 [REDACTED]</p> <p>25 [REDACTED]</p>	<p>Page 68</p> <p>1 [REDACTED]</p> <p>2 [REDACTED]</p> <p>3 [REDACTED]</p> <p>4 [REDACTED]</p> <p>5 [REDACTED]</p> <p>6 [REDACTED]</p> <p>7 [REDACTED]</p> <p>8 [REDACTED]</p> <p>9 [REDACTED]</p> <p>10 [REDACTED]</p> <p>11 [REDACTED]</p> <p>12 [REDACTED]</p> <p>13 [REDACTED]</p> <p>14 [REDACTED]</p> <p>15 [REDACTED]</p> <p>16 [REDACTED]</p> <p>17 [REDACTED]</p> <p>18 [REDACTED]</p> <p>19 [REDACTED]</p> <p>20 [REDACTED]</p> <p>21 [REDACTED]</p> <p>22 [REDACTED]</p> <p>23 [REDACTED]</p> <p>24 [REDACTED]</p> <p>25 [REDACTED]</p>
<p>Page 67</p> <p>1 [REDACTED]</p> <p>2 [REDACTED]</p> <p>3 [REDACTED]</p> <p>4 [REDACTED]</p> <p>5 [REDACTED]</p> <p>6 [REDACTED]</p> <p>7 [REDACTED]</p> <p>8 [REDACTED]</p> <p>9 [REDACTED]</p> <p>10 [REDACTED]</p> <p>11 [REDACTED]</p> <p>12 [REDACTED]</p> <p>13 [REDACTED]</p> <p>14 [REDACTED]</p> <p>15 [REDACTED]</p> <p>16 [REDACTED]</p> <p>17 [REDACTED]</p> <p>18 [REDACTED]</p> <p>19 [REDACTED]</p> <p>20 [REDACTED]</p> <p>21 [REDACTED]</p> <p>22 [REDACTED]</p> <p>23 [REDACTED]</p> <p>24 [REDACTED]</p> <p>25 [REDACTED]</p>	<p>Page 69</p> <p>1 [REDACTED]</p> <p>2 [REDACTED]</p> <p>3 [REDACTED]</p> <p>4 [REDACTED]</p> <p>5 [REDACTED]</p> <p>6 [REDACTED]</p> <p>7 [REDACTED]</p> <p>8 [REDACTED]</p> <p>9 [REDACTED]</p> <p>10 [REDACTED]</p> <p>11 [REDACTED]</p> <p>12 [REDACTED]</p> <p>13 [REDACTED]</p> <p>14 [REDACTED]</p> <p>15 [REDACTED]</p> <p>16 [REDACTED]</p> <p>17 [REDACTED]</p> <p>18 [REDACTED]</p> <p>19 [REDACTED]</p> <p>20 [REDACTED]</p> <p>21 [REDACTED]</p> <p>22 [REDACTED]</p> <p>23 [REDACTED]</p> <p>24 [REDACTED]</p> <p>25 [REDACTED]</p>

18 (Pages 66 to 69)

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<p style="text-align: right;">Page 70</p> <p>1 [REDACTED] 2 [REDACTED] 3 [REDACTED] 4 [REDACTED] 5 [REDACTED] 6 [REDACTED] 7 [REDACTED] 8 [REDACTED] 9 [REDACTED] 10 [REDACTED] 11 [REDACTED] 12 [REDACTED] 13 [REDACTED] 14 [REDACTED] 15 [REDACTED] 16 [REDACTED] 17 [REDACTED] 18 [REDACTED] 19 [REDACTED] 20 [REDACTED] 21 [REDACTED] 22 [REDACTED] 23 [REDACTED] 24 [REDACTED] 25 [REDACTED]</p>	<p style="text-align: right;">Page 72</p> <p>1 [REDACTED] 2 [REDACTED] 3 [REDACTED] 4 [REDACTED] 5 [REDACTED] 6 [REDACTED] 7 [REDACTED] 8 [REDACTED] 9 [REDACTED] 10 [REDACTED] 11 [REDACTED] 12 [REDACTED] 13 [REDACTED] 14 [REDACTED] 15 [REDACTED] 16 [REDACTED] 17 [REDACTED] 18 [REDACTED] 19 [REDACTED] 20 [REDACTED] 21 [REDACTED] 22 [REDACTED] 23 [REDACTED] 24 [REDACTED] 25 [REDACTED]</p>
<p style="text-align: right;">Page 71</p> <p>1 [REDACTED] 2 [REDACTED] 3 [REDACTED] 4 [REDACTED] 5 [REDACTED] 6 [REDACTED] 7 [REDACTED] 8 [REDACTED] 9 [REDACTED] 10 [REDACTED] 11 [REDACTED] 12 [REDACTED] 13 [REDACTED] 14 [REDACTED] 15 [REDACTED] 16 [REDACTED] 17 [REDACTED] 18 [REDACTED] 19 [REDACTED] 20 [REDACTED] 21 [REDACTED] 22 [REDACTED] 23 [REDACTED] 24 [REDACTED] 25 [REDACTED]</p>	<p style="text-align: right;">Page 73</p> <p>1 [REDACTED] 2 [REDACTED] 3 Q. Did you review the donor's health 4 summary? 5 A. Yes. 6 Q. From UNet? 7 A. Yes. 8 Q. When? 9 A. I -- I don't know if the offer was done 10 the night before or during the day. I can't 11 remember exactly. 12 Q. How much time would you generally spend 13 going through the UNOS records that are made 14 available to you? 15 A. Around a half an hour. 16 Q. Do you remember if there were other 17 hearts that were offered to Noah that day that 18 were just as suitable for him? 19 A. No. There wasn't any. 20 [REDACTED] 21 [REDACTED] 22 [REDACTED] 23 [REDACTED] 24 [REDACTED] 25 [REDACTED]</p>

19 (Pages 70 to 73)

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1 [REDACTED]
 2 [REDACTED]
 3 [REDACTED]
 4 Q. Okay. How long do you think Noah could
 5 have waited to get a heart?
 6 A. It's -- it's --
 7 You can't predict that. He could have
 8 died next day.
 9 Q. Do you think he probably would have
 10 died the next day if you --
 11 A. Could have happened. I've seen it many
 12 times.
 13 Q. Well he survived for a week even after
 14 you took his heart out and left him without a
 15 heart; right?
 16 A. Yeah, because I implanted acute
 17 circulatory support on him.
 18 Q. Sure. Weren't --
 19 Wouldn't there have been lots of
 20 intermediate steps to help Noah's circulatory
 21 function if he had continued to go downhill in
 22 the week or two after the 29th if he had chosen
 23 to wait?
 24 A. If he had chosen to work, let's suppose
 25 that you need to do more, that will, you know,

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1 worsen his prognosis.
 2 Q. Do you know that the other doctors who
 3 have testified in this case have said Noah could
 4 have survived weeks or months?
 5 A. I don't agree with that.
 6 MR. BRANTINGHAM: Foundation.
 7 Q. Okay.
 8 MR. BRANTINGHAM: Yeah.
 9 A. I don't agree with that and -- because
 10 he was in cardiogenic shock. He had a right
 11 heart catheterization show extremely low cardiac
 12 index, so he could have died next day.
 13 Moreover, he got end-organ dysfunction several
 14 days before. So there was evidence of, you
 15 know, kidney dysfunction and liver dysfunction,
 16 so you don't want your patient to suffer more
 17 organ dysfunction before transplant.
 18 Q. So if he was in such dire straights, do
 19 you know why Dr. Daly didn't transplant him in
 20 the week before you came on the service?
 21 A. I --
 22 The only thing that I recall -- I don't
 23 recall -- recall anything about Dr. Daly. I
 24 recall Dr. Spencer, that he got an offer, and he
 25 has an increasing in his creatinine, so

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1 end-organ dysfunction what I'm telling you, and
 2 so they -- they elected to wait until the kidney
 3 function, you know, could have gotten better,
 4 signs that he was very sick and in cardiogenic
 5 shock.
 6 Q. And it did get better in less than 24
 7 hours; didn't it?
 8 A. I can't recall how were the measurement
 9 of the kidney function, but normally that
 10 happens over two or three days that it get
 11 better, the kidney function. But he didn't have
 12 normal kidney function for sure.
 13 Q. If Noah's kidney function improved over
 14 the course of less than 24 hours, that would be
 15 a good sign for him; wouldn't it?
 16 A. Yeah. But it would be a good sign in
 17 terms of, you know, he had some recovery with
 18 the circulatory support, but what it tell us
 19 that he's in a very borderline situation.
 20 Q. Would you have preferred for Noah to
 21 have had a combined heart-liver transplant?
 22 A. No.
 23 Q. Why not?
 24 A. Because a heart-liver transplant
 25 carries a mortality between 30 to 50 percent.

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1 Heart transplant might be two to three percent.
 2 Comparative mortalities that we're talking.
 3 Q. Have you seen the email exchanges where
 4 Dr. Spencer and the rest of the team were
 5 actually pushing for him to get a combined
 6 heart-liver transplant?
 7 A. I -- I don't remember seeing those.
 8 I -- I know that the liver team, which are the
 9 experts, said that he didn't need a liver
 10 transplant.
 11 Q. Do you remember when you gave that
 12 presentation with Dr. Friedman talking about the
 13 advantages of doing a combined heart-liver
 14 transplant?
 15 A. Yeah. That has some advantages related
 16 to the antibodies that have been published here
 17 at Mayo.
 18 Q. One of the other advantages is that you
 19 avoid coagulopathy; right?
 20 A. Well that -- that, in terms of if you
 21 implant the liver and it works fine, it might,
 22 you know, get the -- the coagulation better, but
 23 certainly not normal, because when you do a
 24 heart-liver transplant there is a huge
 25 derangement on the coagulation factors. So if

20 (Pages 74 to 77)

<p style="text-align: right;">Page 78</p> <p>1 you ask me what has more coagulopathy, certainly</p> <p>2 a heart-liver, but within the heart-livers,</p> <p>3 doing the liver first would have less</p> <p>4 coagulopathy.</p> <p>5 Q. And as you said in your interview with</p> <p>6 Dr. Friedman, "there's less coagulopathy, so the</p> <p>7 liver is working" and "patients bleed less," and</p> <p>8 that's quite an advantage. That's right; right?</p> <p>9 A. It has not been demonstrated</p> <p>10 extensively, but it's a physiologic thought.</p> <p>11 Q. Do you think that Noah's liver</p> <p>12 dysfunction had anything to do with the bleeding</p> <p>13 event you experienced in the operating room?</p> <p>14 A. No, I don't think so.</p> <p>15 Q. Why is that?</p> <p>16 A. Because we, you know, rely on the</p> <p>17 assessment of the expert, the liver transplant</p> <p>18 people, that his synthetic function was good</p> <p>19 before the transplant, and that includes the</p> <p>20 coagulation, so -- and as a doctor, what I can</p> <p>21 see, his coagulation was good and -- but -- and</p> <p>22 so I don't think it has nothing to do.</p> <p>23 Q. If his coagulation good -- was good,</p> <p>24 why were you unable to get the bleeding from his</p> <p>25 heart to stop?</p>	<p style="text-align: right;">Page 80</p> <p>1 aorta blood, you know, that, you know, might</p> <p>2 cause a tear on the aorta, you know. So, as I</p> <p>3 said, we normally see a little -- little</p> <p>4 bruising, and in this case we saw a little</p> <p>5 bruising also. But, you know, that progressed,</p> <p>6 you know, after the heart was transplanted, I --</p> <p>7 and causing the significant bleeding.</p> <p>8 Q. Where was the bruising that you saw</p> <p>9 when the heart came out of the OCS machine?</p> <p>10 A. Normally there's a little bit in the --</p> <p>11 in the fat that is around the aortic root.</p> <p>12 Q. And that's where it was in this case?</p> <p>13 A. Yeah.</p> <p>14 Q. What percentage of hearts that come off</p> <p>15 the OCS have bruising that looks like that?</p> <p>16 A. Ninety percent.</p> <p>17 Q. Ninety?</p> <p>18 A. Well I mean I haven't done the</p> <p>19 statistics, but like educated guess.</p> <p>20 Q. In your experience.</p> <p>21 A. Yes. Ninety percent.</p> <p>22 Q. You described the heart as being large</p> <p>23 when you retrieved it from the OCS device. Was</p> <p>24 it large as in it was edematous?</p> <p>25 A. No, it was large in size. The -- the</p>
<p style="text-align: right;">Page 79</p> <p>1 A. Well because it was bleeding diffusely,</p> <p>2 you know. It's for me just a theory -- I don't</p> <p>3 know what it was bleeding. It's first time I</p> <p>4 have seen this, so it was bleeding from all over</p> <p>5 the heart, so my suspicion there was, you know,</p> <p>6 microtears on the aortic root and that</p> <p>7 infiltrated the heart and make it bleed from</p> <p>8 everywhere. It's a hypothesis. I don't know</p> <p>9 really what it -- why it bled from everywhere.</p> <p>10 Q. That hypothesis that you just described</p> <p>11 about there being microtears from the aortic</p> <p>12 root, --</p> <p>13 A. Uh-huh.</p> <p>14 Q. -- that's the best hypothesis you can</p> <p>15 come up with based on your years of</p> <p>16 education, --</p> <p>17 A. Uh-huh.</p> <p>18 Q. -- training, and experience and the</p> <p>19 fact that you were the one who was actually</p> <p>20 there watching it bleed; right?</p> <p>21 A. Yep. Yes, sir.</p> <p>22 Q. Where would those microscopic tears</p> <p>23 have come from?</p> <p>24 A. Because the OCS, you know, perfuses</p> <p>25 blood on the aorta. So if you perfuse on the</p>	<p style="text-align: right;">Page 81</p> <p>1 heart didn't have hypertrophy as was</p> <p>2 demonstrated by the echocardiogram on the donor.</p> <p>3 There was no hypertrophy. It was just large in</p> <p>4 size.</p> <p>5 Q. Is it part of your usual practice to do</p> <p>6 a predicted heart mass calculation prior to</p> <p>7 transplant?</p> <p>8 A. Not usually.</p> <p>9 Q. Why not?</p> <p>10 A. Because we would rely on other factors,</p> <p>11 the height, the weight, the gender of the donor,</p> <p>12 the gender of the recipient. And, for example,</p> <p>13 the -- the donor hearts that are 70 kilograms or</p> <p>14 higher in weight, they usually will be adequate</p> <p>15 for all recipients in terms of hemodynamic</p> <p>16 performance. And then you have to assess if the</p> <p>17 heart will fit in the chest, so we normally do</p> <p>18 measurements on the CT scan on the donor, and</p> <p>19 measurements on the CT scan on the recipient to</p> <p>20 see if the heart will fit.</p> <p>21 Q. And you were fine --</p> <p>22 A. But the -- but the ultimate test is</p> <p>23 putting it in.</p> <p>24 Q. Sure. And in this case you had to make</p> <p>25 some adjustments in order to get it to fit.</p>

21 (Pages 78 to 81)

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1 **A. Yep.**

2 Q. All right. The beginning of your
3 operative report you say, "Once I gave word that
4 the donor heart was suitable for
5 transplantation, the patient was anesthetized."
6 Would that have been after you got the call from
7 the procurement team in Idaho?

8 **A. Yeah. Not --**

9 **Well in heart transplantation, there's**
10 **minimum morbidity of putting somebody under**
11 **general anesthesia, so it depends a little bit**
12 **on the situation. In his case, I waited for the**
13 **heart to be on the -- I can't recall exactly,**
14 **but most of the time I would wait for the word**
15 **that it's fine, and then if it's fine, then**
16 **general anesthesia allowing some prepping and**
17 **draping. And then we try to match the -- when**
18 **the heart arrives when the -- with the**
19 **explantation.**

20 Q. Sure. So make sure I've got this
21 right. Anesthetized probably shortly after you
22 got the call from Idaho --

23 **A. Uh-huh.**

24 Q. -- that we've evaluated the heart, it
25 looks good.

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1 **A. Okay. Yeah, likely. I can't recall**
2 **ex -- what was the timing exactly, but that's**
3 **the most common thing. In a patient like Mr.**
4 **Noah, because he -- you know, sometimes you need**
5 **more time because the -- this -- you anticipate**
6 **a complicated operation, so you would**
7 **anesthetize earlier than that.**

8 Q. Noah had what's known as a virgin
9 chest; right?

10 **A. Yeah, he did.**

11 Q. I assume that you had no problems
12 whatsoever accessing his native heart and
13 explanting it?

14 **A. Yeah. I had no problems that I**
15 **remember.**

16 Q. How long did it take?

17 **A. It would take around, to explanted**
18 **it --**

19 **Well one thing is the explantation,**
20 **one -- a different thing is the -- you know,**
21 **open it up. So if you -- if you count from the**
22 **skin incision to get the heart out, an hour, an**
23 **hour and a half.**

24 Q. When -- when would you have made the
25 skin incision?

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1 **A. The -- the skin incision, we would do**
2 **it -- we anticipate the -- the estimated time of**
3 **arrival. So, you know, if it take me an hour,**
4 **an hour and a half, you know, to open,**
5 **cannulate, take me an hour and a half, so we --**
6 **when the airplane is usually on the air, then we**
7 **see what is the estimated time of arrival and**
8 **try to match it the best we can.**

9 Q. I understand.

10 So the goal, in terms of timing, would
11 be you've made the incision, you've done --
12 you've cracked the chest, you've got everything
13 cannulated, you are basically ready to remove
14 the heart when you get the call from the ground
15 in Rochester that they've landed safely.

16 **A. It depends, again, on what's the**
17 **complexity. In his case, I mean we don't crack**
18 **the chest, we do a midline sternotomy.**

19 Q. Okay.

20 **A. And so most of the time, if it's a**
21 **virgin chest, we'll be with the chest open and**
22 **cannulated, so when they land and they tell us**
23 **that the heart is fine, then it will go bypass**
24 **and take the heart out.**

25 Q. Got it.

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1 Fair to say you don't remember for sure
2 if that's what you did in this case, but based
3 on your general practice you think that's
4 probably what happened.

5 **A. Yeah.**

6 Q. Describe for me --

7 You write in your operative note about
8 adjusting the sutures, opening the posterior and
9 left-side pericardium to make this larger heart
10 fit.

11 **A. Uh-huh.**

12 Q. Describe what you're talking about
13 there.

14 **A. So the -- the pericardium is the**
15 **linings -- the lining of the heart. So if you**
16 **open it in the back and to the left, you get an**
17 **opening to the left chest so there's more room.**
18 **So that's what I did, I opened -- so I give more**
19 **room to the heart. And then the adjusting of**
20 **the sutures meaning, you know, what we call**
21 **compensating. When we do the suture, we take**
22 **more in one side than the other side. So if you**
23 **sort of -- if you take -- so you have something**
24 **big and something small, you will take normal**
25 **bites in the bigger one while you will take very**

22 (Pages 82 to 85)

1 **close bites on the smaller one.**
 2 Q. Okay. So obviously this was different
 3 because you ended up having to take the heart
 4 out. But if things had gone the way you wanted
 5 them to, would the pericardium have been
 6 completely stitched closed at the end of the
 7 operation?
 8 **A. No, I don't do that.**
 9 Q. Because of swelling?
 10 **A. No. I -- I don't like to close the**
 11 **pericardium, because if you have a closed cavity**
 12 **there's always some oozing of blood, so you**
 13 **could have accumulation of clots and blood and**
 14 **have, you know, tamponade.**
 15 Q. Tamponade.
 16 And so the pericardium would just be
 17 left partially open permanently?
 18 **A. Yes. So I, in all the cases, I**
 19 **leave -- open it permanently on the front.**
 20 Q. On the front.
 21 **A. In this case it was additional on the**
 22 **back to the left.**
 23 Q. Because the heart was bigger than --
 24 **A. Yes.**
 25 Q. Okay. All right. Everything went

1 according to plan until the cross-clamp was
 2 removed. Am I correct about that?
 3 **A. Yes.**
 4 Q. Describe for us then what happened once
 5 you took off the cross-clamp.
 6 **A. So the -- the heart start becoming more**
 7 **bruised overall until it start bleeding from**
 8 **several spots. And we normally handle the heart**
 9 **to check, you know, for bleeding in the back and**
 10 **the front. So all those, when we grabbed,**
 11 **that -- so we grabbed the heart, and then that**
 12 **kind of broke off the epicardium, you know, the**
 13 **layers or bled through there, and then that**
 14 **process continue.**
 15 Q. Was the blood infiltration spreading
 16 from that location of ecchymosis near the aortic
 17 root?
 18 **A. I don't know because it was all over**
 19 **the place, so I don't know.**
 20 Q. It was all over the place by the time
 21 you noticed it.
 22 **A. Yeah.**
 23 Q. Okay. All right. Estimate of how many
 24 different places it looked like it was bleeding
 25 from when you first noticed it.

1 **A. You cannot quantify because it's**
 2 **diffuse bleeding, so you can't count it.**
 3 Q. All right. At what point in the
 4 process did you begin to suspect that it was
 5 these microscopic tears?
 6 **A. When -- when there was bleeding from**
 7 **all over the place, so I -- I -- I suspect that**
 8 **that could have been the case.**
 9 Q. Okay. What did you do about it?
 10 **A. I -- I --**
 11 **You know, you are fully anticoagulated**
 12 **when you are in that situation because you on**
 13 **the heart-lung bypass machine, you need to do**
 14 **that fully anticoagulated, so I -- I came off --**
 15 **off the heart-and-lung bypass machine and I gave**
 16 **protamine. We tried to seal those suspected**
 17 **microscopic holes.**
 18 Q. And that didn't work.
 19 **A. No, it didn't. And actually the heart,**
 20 **it squeeze quite well, had normal function at**
 21 **the beginning. But as it get more and more**
 22 **infiltrated, the function, you know, went down.**
 23 Q. Okay. Were you -- your assistant
 24 was --
 25 You had one assistant. It was a

1 fellow; right?
 2 **A. Yeah.**
 3 Q. Did you, during this time, did you
 4 contact either Dr. Daly or Dr. Spencer?
 5 **A. No, I didn't.**
 6 Q. All right. How long did you spend
 7 trying to get the bleeding under control?
 8 **A. Several hours.**
 9 Q. Do you think that there may have been a
 10 component of DIC involved here?
 11 **A. I -- I haven't heard about any labs**
 12 **confirming or denying that. Nobody told me**
 13 **anything about that.**
 14 Q. Well after the fact I presume that you
 15 were racking your brain and looking at the data
 16 and trying to figure out what happened here to
 17 cause this thing that I've never seen.
 18 **A. Yeah. But, you know, I -- I'm hands**
 19 **on, you know, trying to get the patient to stop**
 20 **bleeding, so normally the -- the**
 21 **anesthesiologist will be looking at all the**
 22 **coagulation tests, and if there's anything**
 23 **abnormal, they try to correct it the best they**
 24 **can.**
 25 Q. And the anesthesiologist didn't say

1 anything to you about there being a
2 coagulopathy.

3 **A. Well I, you know, I knew that he had**
4 **coagulopathy because the way, you know, it was**
5 **bleeding all the time. So he had coagulopathy**
6 **as 90 percent of the heart transplant we do,**
7 **they have coagulopathy.**

8 Q. Yep.

9 **A. So -- so we gave --**

10 **We usually do two things. We'll give**
11 **blood products and we give concentrated blood**
12 **products, meaning like a powder of, you know,**
13 **clotting factors that is, you know, injected**
14 **intravenously. So that was tried. It was tried**
15 **when we give the protamine and it was tried**
16 **again. You know, then I, you know, had to go on**
17 **the heart-and-lung bypass machine and then I**
18 **went on -- on ECMO to give more support to the**
19 **heart. And then we gave more products, more**
20 **concentrated of blood products, and the bleeding**
21 **would not subside.**

22 Q. And then eventually you decided the
23 only thing left to do is take this heart out.

24 **A. Yes.**

25 Q. Is that the first time that you have

1 **circulatory and gas-exchange support.**

2 Q. How does that setup differ from ECMO?

3 **A. It's just in -- in ECMO you have the --**
4 **the heart is still in. So you have the can --**
5 **cannula, you know, on the right femoral vein and**
6 **another one here in the artery here or here.**
7 **Actually we had that for a little while.**

8 Q. Yep.

9 **A. And that's the difference, in one**
10 **there's heart, in the other one there's no**
11 **heart.**

12 Q. Okay. So this BiVAD setup, the BiVAD
13 is basically taking the place of the heart.

14 **A. Yes.**

15 Q. Because without either a donated heart
16 or the explanted native heart, there was nothing
17 for things to flow through without putting in
18 the BiVAD?

19 **A. Yeah. Because it, you know, it was**
20 **bleeding all over the place so, you know, my**
21 **alternatives was let the patient die on the**
22 **table or attempt a BiVAD oxygenator.**

23 Q. After the surgery was finished, did you
24 talk with Noah's family?

25 **A. I remember talking multiple times to**

1 left a patient without a heart?

2 **A. No. The -- there was a colleague of**
3 **mine that had a bleeding -- it's called an**
4 **atrioventricular dysjunction, you know, the**
5 **atrium and the ventricle, they separated, and**
6 **then you try to put it back together. And then**
7 **we tried everything for that and it didn't work,**
8 **so we took the heart out, the patient stopped**
9 **bleeding.**

10 Q. Tell me about this attempt to put in a
11 BiVAD oxygenator implant.

12 **A. Uh-huh.**

13 Q. First of all, what is it?

14 **A. So it is essentially cannulas to drain**
15 **the blood. We put one cannula here on the right**
16 **femoral vein, another one here, so trying to**
17 **re-create the normal circulatory system. So**
18 **cannulas drain the blood from the veins, then**
19 **inject them from the pulmonary artery, then**
20 **coming back from the pulmonary veins, and then**
21 **drain it to another pump, and then that's going**
22 **into the outer, to the rest of the body.**
23 **That's -- and then you inter -- in one of those**
24 **circuits or those pumps you'll interpose an**
25 **oxygenator to oxygenate the patient, so provide**

1 **them.**

2 Q. Tell me what you remember.

3 **A. Essentially the description that I gave**
4 **you, that the heart, after we took the**
5 **cross-clamp out, got an extensive hematoma,**
6 **started bleeding from everywhere. We tried to**
7 **fix it with all these maneuvers that I have just**
8 **told you. The same story.**

9 Q. Did you tell them that you suspected
10 that it was -- the cause of this was related to
11 the perfusion on the OCS machine?

12 **A. Yeah, yeah. I -- I told them that.**
13 **Because they tell me, "Why -- why -- why that**
14 **would happen?" I said, "I suspect that there**
15 **might be micro -- microholes, you know, that**
16 **caused this."**

17 Q. How would the holes have been created,
18 with the pressure from the perfusion?

19 **A. With the pressure of the perfusion.**

20 Q. So this is something that's never been
21 reported anywhere else in the world; true?

22 **A. I -- I have not seen it myself before.**

23 Q. Have you heard of it?

24 **A. No.**

25 Q. If it was the pressure from the OCS

<p style="text-align: right;">Page 94</p> <p>1 machine that caused these little microholes in 2 the aortic root, why would that have never 3 happened before? 4 A. May -- maybe the -- 5 You know, you don't know what the 6 resistance of the tissues of each person. Each 7 person is different, so maybe this one has less 8 resistance. 9 Q. Yeah. That's kind of where I was going 10 with it. It sounds like -- it sounds like 11 whatever the problem was, it was something wrong 12 with that heart; right? 13 MR. BRANTINGHAM: Foundation. Go 14 ahead. 15 A. That -- that could not be stated with 16 our current methods of diagnosis. 17 Q. Your best explanation is that there was 18 something wrong with the heart. 19 MR. BRANTINGHAM: Same objection. Go 20 ahead. 21 A. Well after the fact. 22 Q. Sure. No. Absolutely. 23 A. In hindsight. 24 Q. Does this event give you any concern 25 about the use of OCS for other donor hearts?</p>	<p style="text-align: right;">Page 96</p> <p>1 Have you written or are you intending 2 to write a case report or anything else about 3 this case? 4 A. Well there has been at least two 5 doctors in training at the Mayo Clinic that have 6 wanted to report this case. And I suspected it 7 could have legal implications, so I told them to 8 wait. 9 Q. Help me understand that, please. 10 A. You know, because, you know, if, you 11 know, the -- the family, you know, would, you 12 know, make a claim against us, you know, we 13 don't want to, you know, publish it in the 14 newspaper. 15 Q. So the reason that one would put out a 16 case report about this is so that other doctors 17 can be aware that this happened and let's try to 18 figure out how we can try to prevent it from 19 happening again; right? 20 A. Yep. But I would let the dust settle 21 so there's no emotional decisions taken. 22 Q. No, no. Let's stick with my question 23 though. 24 The reason that stuff gets published in 25 the medical literature is so that the medical</p>
<p style="text-align: right;">Page 95</p> <p>1 A. Well it gives me a concern, of course. 2 You know, we remember our bad experiences, so -- 3 Q. I'm talking about, though, specifically 4 with respect to OCS. So the best explanation 5 you've been able to come up with this is that 6 there was something about the pressure on the 7 OCS machine perfusing the aortic root that 8 caused little microperforations that led to this 9 disastrous -- 10 A. Yeah. 11 Q. -- transplant attempt. Does that give 12 you pause in using the OCS in the future? 13 A. Well but I have to see the bulk of my 14 experience with OCS. So I have been able to 15 transplant successfully many, many patients with 16 the OCS. So it's important not to be guided 17 emotionally, but be guided scientifically and 18 see if it would happen ever again. 19 Q. Now there have been a number of 20 studies, and there are ongoing studies, about 21 the OCS; true? 22 A. (Witness nodding.) 23 Q. Yes? You got to -- 24 A. Yes. 25 Q. -- say yes.</p>	<p style="text-align: right;">Page 97</p> <p>1 community can benefit from sort of the high of 2 mind; right? 3 A. That's one of the benefits. 4 Q. Right. 5 And specifically, with respect to this 6 incident, it could have implications for the OCS 7 if your hypothesis is true; right? 8 A. Yeah. 9 Q. And some of your colleagues want to 10 write a case report about this case to put it 11 out there into the medical literature to get 12 other people thinking about it in order to 13 advance science and patient safety; right? 14 A. Yeah. We likely will. 15 Q. But you're telling me that Mayo has 16 elected not to do that -- 17 A. No. I told them not to do it yet. 18 Q. Okay. You told them not to do it yet 19 because you're worried that there may be legal 20 ramifications. 21 A. Yes. 22 Q. And legal ramifications are you don't 23 want there to be a case report that's going to 24 be out there in the newspaper. 25 A. Well I -- I don't want bad publicity</p>

25 (Pages 94 to 97)

<p style="text-align: right;">Page 98</p> <p>1 certainly.</p> <p>2 Q. Why not?</p> <p>3 A. Because that will affect Mayo and other</p> <p>4 patients -- will affect other patients mainly.</p> <p>5 They would, you know, not receive the care that</p> <p>6 they need.</p> <p>7 Q. So you're withholding potentially</p> <p>8 important scientific information in order to</p> <p>9 avoid bad -- bad publicity for Mayo.</p> <p>10 A. No, sir.</p> <p>11 Q. Okay. Have you reported this to</p> <p>12 TransMedics?</p> <p>13 A. No.</p> <p>14 Q. Why not?</p> <p>15 A. Because we wanted the dust settled</p> <p>16 before tell other people.</p> <p>17 Q. How long are you waiting for the dust</p> <p>18 to settle?</p> <p>19 A. Until we're finished with your claim.</p> <p>20 Q. Okay. So hold on. Your best</p> <p>21 hypothesis is that there was something about</p> <p>22 this OCS machine's perfusion that caused a</p> <p>23 catastrophic loss of this donor heart. Yes?</p> <p>24 That's your best hypothesis.</p> <p>25 A. Yes.</p>	<p style="text-align: right;">Page 100</p> <p>1 MR. BRANTINGHAM: Go ahead, you can</p> <p>2 answer.</p> <p>3 Q. Okay. So what am I missing? Tell me</p> <p>4 about this conversation.</p> <p>5 A. No. There's -- there's -- there's, you</p> <p>6 know, the International Society of Heart and</p> <p>7 Lung Transplantation meeting, and then we see</p> <p>8 all the people there, you know, including --</p> <p>9 including the TransMedics people because they</p> <p>10 present their technology, so they told me there</p> <p>11 was a lawyer looking for the records.</p> <p>12 Q. Who told you?</p> <p>13 A. I don't remember.</p> <p>14 Q. Somebody from TransMedics.</p> <p>15 A. Yeah.</p> <p>16 Q. And it was while you were at the</p> <p>17 International Heart/Lung Transplantation Society</p> <p>18 meeting?</p> <p>19 A. Yes.</p> <p>20 Q. Where?</p> <p>21 A. In Prague.</p> <p>22 Q. In Prague?</p> <p>23 When?</p> <p>24 A. In April.</p> <p>25 Q. Have you talked to anybody else about</p>
<p style="text-align: right;">Page 99</p> <p>1 Q. You certainly know that TransMedics</p> <p>2 would like to know about this.</p> <p>3 A. They already know.</p> <p>4 Q. How?</p> <p>5 A. Because you already reached to them.</p> <p>6 Q. Right. I reached to them to get</p> <p>7 medical records.</p> <p>8 How do you know that, by the way?</p> <p>9 A. They -- they told me. You know, I was</p> <p>10 told that -- that -- I don't remember who it was</p> <p>11 that told me that you were asking about the --</p> <p>12 the records.</p> <p>13 Q. Oh, somebody at TransMedics?</p> <p>14 A. Yeah, likely.</p> <p>15 Q. Got it.</p> <p>16 A. Filtrated.</p> <p>17 Q. So I called to get --</p> <p>18 I contacted TransMedics to get records,</p> <p>19 and TransMedics called you and said --</p> <p>20 A. No.</p> <p>21 Q. -- "Hey, just so you know, some</p> <p>22 lawyer's poking around."</p> <p>23 MR. BRANTINGHAM: Object to the form of</p> <p>24 the question.</p> <p>25 A. No.</p>	<p style="text-align: right;">Page 101</p> <p>1 this?</p> <p>2 A. No.</p> <p>3 Q. Nobody?</p> <p>4 A. I think I told my -- my chairman. I</p> <p>5 think I -- for some reason I had to tell my</p> <p>6 chairman, I don't know why, and the director of</p> <p>7 the transplant center here, but other than that.</p> <p>8 Q. Have you talked with any of the people</p> <p>9 who are currently doing research on the OCS?</p> <p>10 A. Like who?</p> <p>11 Q. Well any of your colleagues, people at</p> <p>12 Duke or people at Mass General or people</p> <p>13 anywhere else?</p> <p>14 A. No. No. I was requested not to talk</p> <p>15 to anybody. And I didn't ask this TransMedics</p> <p>16 thing that I was told. They told me. I didn't</p> <p>17 ask in the IHLT meeting. They told me that, so</p> <p>18 I didn't ask. And so I haven't wanted to talk</p> <p>19 to anybody --</p> <p>20 Q. Okay.</p> <p>21 A. -- about it.</p> <p>22 Q. So the people from TransMedics told you</p> <p>23 there's a lawyer asking questions.</p> <p>24 A. Yeah.</p> <p>25 Q. Did you tell them anything more about</p>

26 (Pages 98 to 101)

Page 102

1 the case?
 2 **A. No.**
 3 Q. Did you just -- you say, "I've been
 4 advised to not talk about it?"
 5 **A. I -- I said "Okay" and I walk away.**
 6 Q. You said o --
 7 **A. "Okay" --**
 8 Q. And walked away.
 9 **A. And then I walk away.**
 10 Q. Did the person from TransMedics think
 11 it was strange that you just said "Okay" and
 12 walked away?
 13 MR. BRANTINGHAM: Foundation.
 14 Q. Did they seem like they thought it was
 15 strange?
 16 **A. No, no, because you have very short**
 17 **conversations normally in these meetings. You**
 18 **talk to somebody and go, talk to somebody and**
 19 **go. It's normal. I don't want to be rude with**
 20 **people, so I -- I don't tell them, you know,**
 21 **"Shut up," you know. I don't -- you know, I**
 22 **don't want to talk to anybody about it. So I**
 23 **was told, I said "Okay," I walk away.**
 24 Q. Why haven't you talked with any of your
 25 cardiac transplant surgery colleagues about this

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1 case outside of Mayo?
 2 **A. In other -- in other centers you mean?**
 3 Q. Outside of Mayo.
 4 **A. Because I was recommended not to talk**
 5 **to anybody about the case. I think this was in**
 6 **February. I believe so.**
 7 MR. BRANTINGHAM: Well don't get into
 8 our communications, doctor, but your best memory
 9 in response to Mr. Thompson's questions is all
 10 you can give him.
 11 **A. I --**
 12 MR. BRANTINGHAM: Let's have another
 13 question because I'm unsure even what the
 14 question is right now.
 15 Q. Did you report this to the FDA?
 16 **A. No, I haven't reported it to FDA.**
 17 Q. Why not?
 18 **A. Because, you know, I was told to not**
 19 **talk to anybody, --**
 20 Q. Well --
 21 **A. -- legal matters.**
 22 Q. Right. But there were no --
 23 There was no legal issue in September
 24 of 2023; right? Right?
 25 THE REPORTER: Your answer?

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1 Q. You got to answer my question.
 2 **A. Yeah. There wasn't, but I suspected**
 3 **there could have been.**
 4 Q. You suspected that maybe there was
 5 going to be a claim as far back as September of
 6 2023?
 7 **A. Yes.**
 8 Q. And so you made the independent
 9 decision that, "Well, because I think there may
 10 be the possibility of a legal claim, I'm keeping
 11 this under wraps and I'm not telling anybody."
 12 MR. BRANTINGHAM: Object to the form of
 13 the question.
 14 **A. Yeah. I -- I prefer not to talk to --**
 15 **again until, you know, I'm sure that there was**
 16 **not going to be any claim.**
 17 Q. And then October passed and November
 18 passed and December passed and you didn't hear
 19 anything about a claim; right?
 20 **A. No, I think I heard it in February.**
 21 Q. No. So we'll get to that.
 22 September, October, November, December,
 23 four months you heard nothing about a claim and
 24 you still kept it under wraps, didn't report it
 25 to the FDA, didn't talk to TransMedics about it,

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1 didn't talk to anybody outside the little Mayo
 2 cocoon.
 3 MR. BRANTINGHAM: Object to the form of
 4 the question. Go ahead.
 5 **A. Yes. I believe that's a short time in**
 6 **clinical terms.**
 7 Q. Okay. Did you think about reporting
 8 it?
 9 **A. Well, yeah, after I'm sure that there's**
 10 **no legal claim.**
 11 Q. Who are your colleagues here who want
 12 to write a case report about it?
 13 **A. The transplant fellow, I believe, and**
 14 **other one I think it was a cardiology fellow --**
 15 **no, no -- an intensivist fellow, but I don't**
 16 **even know his name. I mean I know the name of**
 17 **the cardiac fellow.**
 18 Q. When did they tell you that they want
 19 to write a case report about this?
 20 **A. I don't remember.**
 21 Q. Before February?
 22 **A. I don't --**
 23 **I suspect December, January, I suspect.**
 24 **I can't -- can't recall.**
 25 Q. And you told them "Let's just kind of

27 (Pages 102 to 105)

<p style="text-align: right;">Page 106</p> <p>1 wait for the dust to settle and see if there's a</p> <p>2 legal claim."</p> <p>3 A. Yes.</p> <p>4 Q. Do you know that there is a Patient</p> <p>5 Safety Incident Reporting Guideline at Mayo?</p> <p>6 A. No, I don't.</p> <p>7 Q. Do you know that there is an online</p> <p>8 incident reporting tool available to the</p> <p>9 transplant team at Mayo?</p> <p>10 A. No. I -- I -- I suspect that there</p> <p>11 could be something to report, but -- but -- but</p> <p>12 I -- I haven't used it ever, so I don't know.</p> <p>13 Q. Do you know what the MAUDE database is?</p> <p>14 A. No.</p> <p>15 Q. Do you know that the FDA maintains a</p> <p>16 database that allows doctors to report incidents</p> <p>17 with medical devices so that it can raise</p> <p>18 awareness throughout the medical community?</p> <p>19 A. It would have been already published if</p> <p>20 it wouldn't been a claim, and then everybody</p> <p>21 will be ed -- it would have been educated. But</p> <p>22 because there was a claim, there's no education.</p> <p>23 Q. None of that was my question. I'm</p> <p>24 going to go back to my question.</p> <p>25 A. It is -- it is my answer.</p>	<p style="text-align: right;">Page 108</p> <p>1 ensure you don't talk about our communications,</p> <p>2 doctor, or --</p> <p>3 THE WITNESS: Okay.</p> <p>4 MR. BRANTINGHAM: -- the communications</p> <p>5 with Mayo Legal.</p> <p>6 Q. But I think you told me before that one</p> <p>7 of the reasons why you didn't talk about it,</p> <p>8 even before the legal team got involved, was</p> <p>9 because you didn't want bad publicity for the</p> <p>10 transplant program.</p> <p>11 A. Yeah, I think that's accurate.</p> <p>12 MR. THOMPSON: Let's take a break.</p> <p>13 THE REPORTER: Off the record.</p> <p>14 (Recess taken from 3:11 p.m. to 3:35</p> <p>15 p.m.)</p> <p>16 THE VIDEOGRAPHER: We're on video.</p> <p>17 THE REPORTER: We're on the record.</p> <p>18 MR. BRANTINGHAM: Before you proceed,</p> <p>19 I -- pursuant to the protective order, I want to</p> <p>20 designate this transcript as confidential.</p> <p>21 MR. THOMPSON: All right. Based on?</p> <p>22 MR. BRANTINGHAM: Based on all of the</p> <p>23 PHL, all of the sensitive health information in</p> <p>24 it, based on the totality of everything we're</p> <p>25 talking about.</p>
<p style="text-align: right;">Page 107</p> <p>1 MR. BRANTINGHAM: Wait for the</p> <p>2 question, doctor.</p> <p>3 Q. Are you familiar with the fact that the</p> <p>4 FDA has a publically-accessible database that</p> <p>5 allows doctors to report problems with devices?</p> <p>6 A. No, I'm not aware. What is the</p> <p>7 particular database? I suspect that there's a</p> <p>8 reporting instrument, but I -- I don't know the</p> <p>9 specifics.</p> <p>10 Q. Would you like to report this</p> <p>11 catastrophe to somebody outside of Mayo?</p> <p>12 MR. BRANTINGHAM: Object to the form.</p> <p>13 A. I -- I would like to publish the case</p> <p>14 and at the same time report it to the FDA.</p> <p>15 Q. And you're planning to do that, but</p> <p>16 just you're going to wait until this lawsuit's</p> <p>17 over.</p> <p>18 A. Yes.</p> <p>19 Q. Because you don't want there to be bad</p> <p>20 publicity for your transplant program.</p> <p>21 MR. BRANTINGHAM: Object to the form of</p> <p>22 the question. Go ahead.</p> <p>23 A. Because I -- I have been advised not to</p> <p>24 talk to anybody by my legal team.</p> <p>25 MR. BRANTINGHAM: And -- and just</p>	<p style="text-align: right;">Page 109</p> <p>1 MR. THOMPSON: Okay.</p> <p>2 BY MR. THOMPSON:</p> <p>3 Q. All right. Doctor, despite this event</p> <p>4 that you're planning to someday report to the</p> <p>5 FDA and TransMedics, Mayo is continuing full</p> <p>6 bore using the OCS; right?</p> <p>7 A. Yes.</p> <p>8 MR. BRANTINGHAM: Object to the form of</p> <p>9 the question. Go ahead, doctor.</p> <p>10 A. Yes, we are using OCS for heart</p> <p>11 transplantation.</p> <p>12 Q. You haven't reduced your use of OCS</p> <p>13 since this event; have you?</p> <p>14 A. No, I have not.</p> <p>15 Q. You've increased your use of OCS.</p> <p>16 A. No. I haven't done the statistics, but</p> <p>17 it looks like around the same.</p> <p>18 Q. When you went to Prague for that</p> <p>19 International Society meeting, you presented on</p> <p>20 TransMedics data; right?</p> <p>21 A. Yes.</p> <p>22 Q. Did TransMedics provide you a stipend?</p> <p>23 A. No.</p> <p>24 Q. They didn't cover any of your travel</p> <p>25 expenses, nothing.</p>

28 (Pages 106 to 109)

Page 110

1 **A. No.**
 2 Q. All right. You presented on --
 3 Part of what you presented on was
 4 information about TransMedics NOP program;
 5 right?
 6 **A. OP?**
 7 Q. NOP? Their National --
 8 **A. Oh, the National Organ --**
 9 Q. National OCS Program.
 10 **A. Not -- not quite the same.**
 11 Q. Okay. Let me ask it a different way.
 12 You know about TransMedics' National
 13 OCS Program; right?
 14 **A. Yeah. I have not used it.**
 15 Q. No, I know. But you know what it is?
 16 **A. Yes.**
 17 Q. What it is?
 18 **A. Which is that the transplant**
 19 **procurement surgeons from TransMedics will go**
 20 **and fly out and retrieve an organ on the OCS to**
 21 **the transplant center to get transplanted.**
 22 Q. TransMedics has their own planes;
 23 right?
 24 **A. Yes.**
 25 Q. They've got dedicated people whose only

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1 Wouldn't outcomes be better, presum --
 2 Well let me ask you this question: Do
 3 you agree with the basic concept in medicine
 4 that the more experienced you are, in general,
 5 the better you are at doing things?
 6 **A. Yes.**
 7 Q. One of the reasons why you're trying to
 8 bulk up the transplant numbers in the Mayo heart
 9 transplant program; right?
 10 **A. Yes.**
 11 Q. So wouldn't it stand to reason that if
 12 you've got OCS specialists who literally all
 13 they are doing day in and day out is doing OCS
 14 organ procurement, that would lead to improved
 15 clinical outcomes?
 16 **A. No, sir.**
 17 MR. BRANTINGHAM: Foundation.
 18 **A. That's wrong.**
 19 Q. Are you familiar with TransMedics'
 20 statistics on clinical outcomes for facilities
 21 that are using their people as opposed to using
 22 other people?
 23 **A. No, I don't.**
 24 Q. You haven't even bothered to review
 25 their statistics as part of deciding whether

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1 job is to do organ procurement for OCS
 2 transport; right?
 3 **A. Yes.**
 4 Q. Why doesn't Mayo use that service?
 5 **A. Be --**
 6 **There's two reasons. Because one**
 7 **thing, it's more expensive, so I want to, you**
 8 **know, be as inexpensive as possible. And the**
 9 **second reason is they are -- the surgeons are,**
 10 **you know, TransMedics' employees, so I see a**
 11 **conflict of interest. So I prefer my own people**
 12 **to assess the organs and put them on the device**
 13 **if needed.**
 14 Q. Doesn't it make sense to you to have
 15 the most experienced people possible running
 16 this complicated machine?
 17 **A. Yes, but with no conflict of interest.**
 18 Q. How is it a conflict of interest to
 19 have the most experienced people operating a
 20 machine that they know better than anyone?
 21 **A. Yeah. Because their salary depend on**
 22 **the company, so I want people with no salary**
 23 **from the company.**
 24 Q. How does that --
 25 You got to help me understand that.

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1 you're going to use their TransMedics program?
 2 **A. I don't see -- I --**
 3 **I don't know where are the -- the**
 4 **centers that, you know, doing their own at this**
 5 **point in time.**
 6 Q. Now your hypothesized problem with this
 7 heart was that there was something about the way
 8 that the blood was being perfused into the
 9 aortic root through the OCS system; right?
 10 **A. No, not -- not in the way. I -- I**
 11 **suspect that, you know, all the hemodynamics**
 12 **parameters are good, so I suspect there is**
 13 **something in -- in the tissue of the -- the**
 14 **heart that cannot be assessed with the current**
 15 **diagnostic methods that, you know, made them**
 16 **weakened to filtrate the blood.**
 17 Q. Got it. That this heart that came from
 18 the meth addict, intracranial hemorrhage,
 19 alcoholic, cigarette smoker, convicted felon
 20 with all those drugs in his system, maybe there
 21 was something wrong with his heart.
 22 MR. BRANTINGHAM: I'll object to the
 23 form of the question. If you can an -- go ahead
 24 if you're --
 25 **A. Well looking -- looking back, because**

29 (Pages 110 to 113)

<p style="text-align: right;">Page 114</p> <p>1 there were this bleeding and you could think 2 that there's -- there was something wrong with 3 the heart, but with all the diagnostic tools 4 that we currently have, the -- the heart was 5 excellent. 6 Q. Well you thought the heart was 7 excellent, but now we know, in retrospect, your 8 best hypothesis is there was something wrong 9 with that heart; right? 10 A. The -- 11 No. No. The heart was excellent by 12 the, you know, criteria of the International 13 Society of Heart and Lung Transplantation, you 14 know, published last year. It checked all the 15 boxes for an optimal, excellent heart. 16 Q. Wasn't my question though. 17 Your best hypothesis is there was 18 something with the tissue in that particular 19 heart that made it not able to withstand the 20 perfusion pressures on the OCS machine like 21 every other heart you've ever had on the OCS 22 machine did; right? 23 A. Yes, but I couldn't diagnose that. 24 Q. I know you couldn't diagnose that. But 25 your best hypothesis is there was something</p>	<p style="text-align: right;">Page 116</p> <p>1 A. Yeah. I don't know. 2 Q. Do you know how many OCS runs the OCS 3 specialist from Mayo who was responsible for the 4 perfusion on this heart had been on? 5 A. I don't. I haven't counted. 6 Q. Would it surprise you to know that she 7 testified yesterday that it was probably 8 something like six or seven at the time she did 9 this run? 10 A. I think there were two normally. I 11 think there were two perfusionists normally. 12 Q. Okay. 13 A. So you have the count. I don't know 14 the count of how many have they gone. 15 Q. And as for whether the OCS specialists 16 in the NOP Program are orders of magnitude more 17 experienced than the Mayo people, you just don't 18 know. 19 A. No. I -- I don't know. But -- but 20 again, they have a conflict of interest. So we 21 don't want conflict of interest in the decisions 22 of -- in heart transplantation. 23 Q. I'm still having a hard time 24 understanding the conflict of interest as it 25 applies to patient outcomes. Are you suggesting</p>
<p style="text-align: right;">Page 115</p> <p>1 wrong with that heart; right? 2 A. Yep. 3 MR. BRANTINGHAM: Object to the form. 4 Go ahead. 5 A. Something that was microscopic and not 6 see it with the current diagnosis test again. 7 Q. Well your people didn't see it. We 8 don't know if maybe the more experienced 9 TransMedics people wouldn't have seen it; do we? 10 MR. BRANTINGHAM: Foundation. 11 A. That's very unlikely. 12 Q. Why? 13 A. Because my people are -- are trained 14 and they work in an academic surgical center. 15 TransMedics is not -- doesn't have a Department 16 of Cardiovascular Surgery. So you would think 17 that you would like to have heart surgery, you 18 would go to the Department of Cardiovascular 19 Surgery, not to a company. 20 Q. Do you know how many OCS procurements 21 the TransMedics NOP Program have done? 22 A. I don't. 23 Q. So you don't know how many orders of 24 magnitude more they've done than your people at 25 Mayo.</p>	<p style="text-align: right;">Page 117</p> <p>1 that because these people are paid by 2 TransMedics, they somehow have an incentive to 3 not do as good of a job? 4 A. No, they try to do a good job, as any 5 human being likes to do, but their incentive is 6 different. You know, they are not part of the 7 Department of Surgery, so they are not doing 8 surgery all the time. That is a problem. They 9 are just doing procurements. So in any 10 unexpected thing that can happen, it will be 11 more difficult to, you know, handle because they 12 are not in everyday surgery. And then their 13 incentive is to do more hearts or more lungs. 14 They are -- you know, they do not have an 15 incentive for the outcome as I do. I have to 16 respond to the patient and the family -- 17 Q. So you're telling -- 18 A. -- or my institution, et cetera. 19 Q. So your testimony is that having people 20 going and procuring these organs, who all they 21 do is procure organs rather than actually doing 22 surgery, is a problem. 23 A. Yes. 24 Q. You know that Dr. Altarabsheh literally 25 only procures organs; right?</p>

30 (Pages 114 to 117)

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1 **A. No.**
 2 MR. BRANTINGHAM: Object to form.
 3 **A. No, no. He doesn't.**
 4 Q. That was his testimony under oath.
 5 **A. No. He doesn't.**
 6 MR. BRANTINGHAM: Hang on. Just hang
 7 on. That's not a question.
 8 Q. Are --
 9 Is it your testimony that you think
 10 that Dr. Salah Altarabsheh does something else
 11 for Mayo other than procure organs?
 12 **A. Yes.**
 13 Q. Would it surprise you to know that his
 14 testimony under oath on Monday was that that
 15 literally is all he does for Mayo?
 16 MR. BRANTINGHAM: Object to foundation.
 17 **A. Well that would have been wrong because**
 18 **I have seen him in the -- in the OR working.**
 19 Q. Doing what?
 20 **A. Heart surgery.**
 21 Q. What kind of heart surgery?
 22 **A. Helping in heart surgery, assisting.**
 23 Q. Helping. What does he do when he's
 24 helping?
 25 **A. Like any doctor helps in surgery, you**

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1 **know, goes in front of the primary surgeon and**
 2 **helps expose, hold the stitches, aspirate, so on**
 3 **and so forth.**
 4 Q. Okay. I want to get a list of all the
 5 things that Dr. Altarabsheh does that makes him
 6 more competent than these TransMedics people.
 7 He helps with exposure sometimes; right?
 8 **A. Yeah.**
 9 Q. Okay. He holds stitches. Is that what
 10 you said?
 11 **A. Yeah. So he's a first assist in**
 12 **surgery.**
 13 Q. Yeah. What else have you seen him do?
 14 **A. Well he goes to the conferences.**
 15 **There's morbidity and mortality conferences, so**
 16 **he discuss the cases here -- here in the -- in**
 17 **the board reviews, in knowledge-review content,**
 18 **all the academic work that is done at the Mayo**
 19 **Clinic Department of Cardiovascular Surgery.**
 20 Q. Yeah. We're going to stick just with
 21 skills for now, so --
 22 **A. That's a skill, sir.**
 23 Q. Technical skills.
 24 **A. Those are technical skills.**
 25 Q. Attending conferences?

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1 **A. Yes. When you go and discuss a case in**
 2 **a conference, that's a technical skill --**
 3 Q. Got it.
 4 **A. -- where you have to learn, you know,**
 5 **how to do things and what's the most appropriate**
 6 **treatment.**
 7 Q. Let's talk about what he's doing in
 8 surgery. I want to make sure I get a complete
 9 list of the things that you say you've seen Dr.
 10 Altarabsheh do in the operating room at Mayo.
 11 You said he helps with exposure, sometimes he
 12 holds stitches. What else have you seen him do
 13 in the operating room?
 14 **A. He helps from the surgery from start to**
 15 **finish, open the chest, close the chest.**
 16 Q. That would be helping with exposure;
 17 right?
 18 **A. Yes.**
 19 Q. So let's --
 20 **A. That's surgery.**
 21 Q. Yeah. No, I know.
 22 **A. What -- what else -- what else are you**
 23 **asking about?**
 24 Q. I'm -- I'm not a heart surgeon and I'm
 25 not the one --

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1 **A. Well --**
 2 Q. Just hold on.
 3 MR. BRANTINGHAM: Hang on. Yeah,
 4 just --
 5 Q. You asked me a question. Now I'm going
 6 to try to provide you information to clarify
 7 what I'm trying to get at here.
 8 You're the one who testified that the
 9 people in the TransMedics NOP Program aren't as
 10 competent as your Mayo people because all they
 11 do is procure organs. I pointed out to you that
 12 Dr. Altarabsheh testified that all he does is
 13 procure organs. And now you're saying that's
 14 not true, I've seen him do stuff in the OR.
 15 **A. Correct.**
 16 Q. So now I'm trying to get a complete
 17 list from you of the things that you have seen
 18 Dr. Altarabsheh do in a Mayo operating room, and
 19 so far we've got he helps with exposure and
 20 sometimes he holds stitches. What else does he
 21 do in the operating room?
 22 **A. Suctions.**
 23 MR. BRANTINGHAM: Go ahead.
 24 **A. He separates.**
 25 Q. Separates what?

31 (Pages 118 to 121)

<p style="text-align: right;">Page 122</p> <p>1 A. The -- the tissues. He does traction, 2 countertraction. 3 Q. Is there -- 4 A. All -- all the scope of heart surgery. 5 Q. Is there anything that Dr. Altarabsheh 6 does that you wouldn't let a second-year 7 resident do? 8 A. No, he can do way more than that. 9 Q. Well you let second-year residents help 10 with exposure; right? 11 A. No, sir. 12 Q. No? 13 A. No. 14 Q. Okay. How experienced does somebody 15 have to be in their training before you'll let 16 them help with exposure? 17 A. They usually a PGY-7, -8, or -9, so 18 seven years, eight years, or nine years of 19 training. 20 Q. Got it. Got to be in the seventh year 21 of your residency. 22 How about holding stitches? 23 A. Holding stitches, it could be even 24 complicated for a heart surgeon to hold properly 25 a stitch.</p>	<p style="text-align: right;">Page 124</p> <p>1 their residency? 2 A. In being in heart surgery in general, 3 residency, residency practice. 4 Q. Before they can provide suction. 5 A. Yes. If you do suction in an 6 appendectomy then, you know, an intern might be 7 do it. But you do a complicated Fontan 8 operation, you need someone with a lot of years 9 of experience to provide suction. 10 Q. Okay. Holding traction, how 11 experienced -- 12 A. Same, ten or more years. The more the 13 better. 14 Q. I'm -- I'm trying to understand what 15 you mean, though, when you say "ten or more 16 years." Do you mean ten or more years out of 17 medical school, or ten or more years out of your 18 fellowship? 19 A. After -- after medical school, general 20 surgery, cardiothoracic training, independent 21 practice, et cetera. Everything. 22 MR. THOMPSON: Gotcha. I'm going to go 23 ahead and end there, and I'm sure Mr. 24 Brantingham's got some questions he wants to ask 25 you.</p>
<p style="text-align: right;">Page 123</p> <p>1 Q. Okay. How far does somebody have to be 2 in their training in the Mayo program before 3 you'll let them hold stitches? 4 A. In the Mayo program? 5 Q. Well you teach Mayo doctors; right? 6 A. Well I teach Mayo -- Mayo doctors, but 7 they already have learned in general surgery how 8 to hold the stitches in simple operations. In 9 complicated operations, I tell them how to do 10 it. 11 Q. Understood. 12 A. But it's not the only background that 13 Dr. Salah Altarabsheh has. 14 Q. Okay. Providing suction. How 15 experienced does a doctor have to be to provide 16 suction? 17 A. Very experienced. 18 Q. Very experienced? 19 A. Yes. 20 Q. How experienced? 21 A. In heart surgery. 22 Q. How experienced? 23 A. Years. More than ten years of heart 24 surgery. 25 Q. More than 10 years out of</p>	<p style="text-align: right;">Page 125</p> <p>1 MR. BRANTINGHAM: Yeah. I've got a 2 couple questions, doctor. Bear with me one 3 moment. Sorry. 4 EXAMINATION 5 BY MR. BRANTINGHAM: 6 Q. I want to ask about the topics that Mr. 7 Thompson was asking you about with regard to 8 publishing -- or about this case or reporting 9 some issue to the FDA or some other body. Do 10 you -- 11 A. Uh-huh. 12 Q. -- remember those questions? 13 My question for you is: Number one, 14 there are -- are there internal procedures 15 within Mayo or -- and/or within your department 16 to review adverse events or complications? 17 A. Yes, we have the morbidity and 18 mortality conferences and the quap -- I mean 19 quality conferences to review the -- 20 Q. Okay. 21 A. -- cases and look at the overall 22 statistics. 23 Q. Okay. And I -- I'm not going to ask 24 you to talk about any of the conclusions of the 25 process because, as you understand, those are --</p>

32 (Pages 122 to 125)

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1 are legally protected.

2 But with respect to this event and this
3 case, did you follow Mayo procedures in regard
4 to morbidity and mortality in review of the
5 case?

6 **A. Yeah. The case was presented.**

7 Q. Okay. Let's leave it there.

8 Are there people at Mayo in charge of
9 compliance and other issues related to reporting
10 of events?

11 **A. Yes. There's -- there's a whole team
12 in the transplant center for -- to take care of
13 compliance and report what needs to be reported.**

14 Q. And do you rely on those people to
15 determine what needs to be reported and -- and
16 how and when?

17 **A. Yes.**

18 Q. Okay. Do you have any recollection of
19 discussing potential use of -- of OCS with Mr.
20 Leopold or -- and/or his family?

21 **A. It --**

22 **I don't recall exactly the 30-minute
23 conversation or so, but it is -- you know, in
24 most of the cases I will tell them what type of
25 procurement we would use, and if it will be the**

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1 **far equivalent results, and even equivalent
2 results in more complex cases. So you take
3 cases for farther away, if your recipient needs
4 a more complex operation that would need to, you
5 know, wait a long time, and any -- anything, you
6 know, far away, any technical difficulty or --
7 you know, the OCS have shown equivalent results.
8 Also, other type of donors, like the DCD donors,
9 have shown equivalence to brain dead and cold
10 storage -- versus cold storage heart
11 transplantation.**

12 Q. So is this --

13 **A. Even in DCD, the most difficult of the
14 donors.**

15 Q. Okay. Is this a --

16 So is that something that you're
17 telling patients is more risky, or -- or not?

18 **A. No, because it's -- this have
19 demonstrated the same results in more complex
20 situations, so what I have told them that the --
21 the OCS TransMedics help us, you know, to go
22 farther and to be, you know, safer in the most
23 complex operations or in the most complex donors
24 like -- like the DCDs and that will have
25 equivalent results. And likely, you know, if**

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1 **heart in a box -- I usually refer to the heart
2 in a box -- and if the patient understands
3 what's the heart in a box, then we, you know,
4 tell the other patients. So most of the cases,
5 you know, before I -- we go to transplant, I
6 tell them, but I don't recall the 30-minute
7 conversation from that day.**

8 Q. Okay. So am I understanding it
9 correctly that you're saying you don't remember
10 specifically in this case, but in -- in many
11 cases or in most cases you will --

12 **A. Yeah.**

13 Q. -- talk to patients about that?

14 **A. Yeah. I'm almost -- probably in the --
15 When I talk to the people in the
16 outpatient setting, in a hundred percent I'm --
17 get sure that I talk to -- to it, and -- and I
18 would say very likely close to a hundred in the
19 inpatient setting.**

20 Q. Is there any, in your judgment, in your
21 practice, is there any -- is there any risk
22 concern associated with using OCS under the
23 correct circumstances as compared to cold
24 storage or cold transit?

25 **A. Yeah. It is -- it has been shown so**

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1 **they get it transplanted quicker, the waiting-
2 list mortality of -- you know, will be decreased
3 because you get access to more organs. Because
4 what you want to avoid is to have -- to avoid
5 waiting-list mortality, which is somebody in
6 cardiogenic shock is a high risk of death, so
7 you want to avoid the waiting-list mortality.**

8 Q. Okay. I would like to ask about
9 another topic. Mr. Thompson asked you some
10 questions about OPTN guidance. Do you remember
11 that?

12 **A. Yes.**

13 Q. And he read to you some language from
14 an OPTN document, but he actually didn't show
15 you the document; did he?

16 **A. He didn't.**

17 MR. BRANTINGHAM: I'm going to ask to
18 just mark this OPTN document as Exhibit 1.

19 (Exhibit 1 was marked for
20 identification.)

21 BY MR. BRANTINGHAM:

22 Q. If you look on that document, doctor,
23 on the second page there's a header,
24 Recommendations, and then a subheader, Deceased
25 Donor Work Group Recommendations. Do you see

33 (Pages 126 to 129)

<p style="text-align: right;">Page 130</p> <p>1 that?</p> <p>2 A. Yes.</p> <p>3 Q. What does the language after number</p> <p>4 four on that list say?</p> <p>5 A. "The following information should not</p> <p>6 be disclosed: Religion; specific diagnosis;</p> <p>7 ethnicity and race; sexual orientation; chronic</p> <p>8 illness unrelated to the donation; mechanism of</p> <p>9 injury or death."</p> <p>10 Q. You answered some questions about</p> <p>11 whether you disclosed, I think, to the patient</p> <p>12 here the particular mechanism of this donor's</p> <p>13 death. Does, as far as you know, does this</p> <p>14 guidance apply to that question?</p> <p>15 A. Yes, it does.</p> <p>16 Q. And what does it mean?</p> <p>17 A. It means that you cannot disclose that,</p> <p>18 because if I disclose it, I might be banned from</p> <p>19 my transplant practice.</p> <p>20 MR. BRANTINGHAM: I have no further</p> <p>21 questions.</p> <p>22 EXAMINATION</p> <p>23 BY MR. THOMPSON:</p> <p>24 Q. Your testimony is that you think that</p> <p>25 OPTN would ban you from your transplant practice</p>	<p style="text-align: right;">Page 132</p> <p>1 make sure that the recipient and/or their family</p> <p>2 can't track down the donor; right?</p> <p>3 A. Yes.</p> <p>4 Q. Right? Explain to me how telling Noah</p> <p>5 Leopold that the donor was coming from a heart</p> <p>6 that had -- person who had died of an</p> <p>7 intracranial hemorrhage could possibly have led</p> <p>8 to them tracking down the donor.</p> <p>9 MR. BRANTINGHAM: I think this has been</p> <p>10 asked and answered.</p> <p>11 MR. THOMPSON: Not of him.</p> <p>12 THE WITNESS: Yeah.</p> <p>13 MR. BRANTINGHAM: Okay.</p> <p>14 MR. THOMPSON: And you brought it up,</p> <p>15 foolishly, but you did.</p> <p>16 MR. BRANTINGHAM: Well hold on a</p> <p>17 second. You're asking him a completely</p> <p>18 different subject here from what's in -- just</p> <p>19 written in that document.</p> <p>20 MR. THOMPSON: No, I'm not at all.</p> <p>21 MR. BRANTINGHAM: Okay. Go ahead. You</p> <p>22 can answer the question.</p> <p>23 A. Well if the --</p> <p>24 By word of mouth, the transplant</p> <p>25 professional can talk to each other about</p>
<p style="text-align: right;">Page 131</p> <p>1 if you told a patient that the donor heart had</p> <p>2 died of an intracranial hemorrhage.</p> <p>3 A. Yes, they can do that.</p> <p>4 Q. Yeah. Have you ever heard of that ever</p> <p>5 happening?</p> <p>6 A. Yes. They have closed programs for</p> <p>7 poor compliance.</p> <p>8 Q. For telling people that somebody died</p> <p>9 of an intracranial hemorrhage?</p> <p>10 A. For -- for poor compliance.</p> <p>11 Q. That wasn't my question.</p> <p>12 A. And -- and I'll answer your question.</p> <p>13 This goes into -- there's a law, the HIPAA law,</p> <p>14 and they have been questioned, they have been</p> <p>15 sued and have to pay huge amounts of money for</p> <p>16 revealing confidential information and</p> <p>17 deceased-donor information.</p> <p>18 Q. Okay. Both HIPAA and the OPTN</p> <p>19 Guidelines have to do with protecting donor</p> <p>20 anonymity; right?</p> <p>21 A. Protecting what? Donor --</p> <p>22 Q. Donor anonymity.</p> <p>23 A. Yes.</p> <p>24 Q. The whole reason that you're not</p> <p>25 supposed to disclose certain information is to</p>	<p style="text-align: right;">Page 133</p> <p>1 confidential information and the recipient can</p> <p>2 get to know where -- where is that, so they can</p> <p>3 identify them, the donor.</p> <p>4 Q. How?</p> <p>5 A. So they -- they can see who died, you</p> <p>6 know, in, you know, a period, and then talk to</p> <p>7 other people and talk to other people, and</p> <p>8 that's the way that things get usually distorted</p> <p>9 and that -- do not get it right and they do not</p> <p>10 get confidential.</p> <p>11 Q. Yeah. We're going to stick, though,</p> <p>12 with the actual purpose of the regulation, and I</p> <p>13 thought you agreed with me, is to make sure that</p> <p>14 the recipient and/or his family can't track down</p> <p>15 the donor; right?</p> <p>16 MR. BRANTINGHAM: Foundation.</p> <p>17 A. No. They -- they --</p> <p>18 The information should be confidential.</p> <p>19 Q. Confidential in order to keep the</p> <p>20 donor's identity confidential; right?</p> <p>21 A. Yes.</p> <p>22 Q. Okay. So back to my question. Explain</p> <p>23 to me how telling Noah Leopold "Your donor heart</p> <p>24 is coming from somebody who died of an</p> <p>25 intracranial hemorrhage" could possibly lead to</p>

34 (Pages 130 to 133)

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1 the donor being identified.
 2 **A. Yeah. From one person to another**
 3 **can -- the word of mouth, as I already said.**
 4 Q. Word of mouth --
 5 **A. And the other -- let me finish -- and**
 6 **the other thing that can happen, that family can**
 7 **black -- after they get to know after one year**
 8 **or more what happened, they can, you know,**
 9 **blackmail donors or vice versa to say about any**
 10 **confidential like, you know, this donor, we are**
 11 **going to let the people know that this human**
 12 **being, you know, was a drug addict and give --**
 13 **you know, that information and blackmail people.**
 14 **So we want to avoid any, you know, extortion**
 15 **practices --**
 16 Q. Again, --
 17 **A. -- as well.**
 18 Q. -- in order for that to happen, the
 19 recipient's family would have to know who the
 20 donor is; right?
 21 **A. Yeah. They can find out.**
 22 Q. How? You haven't explained it to me.
 23 You said word of --
 24 **A. Well I did it. I did --**
 25 Q. Hold on. Hold on.

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1 MR. BRANTINGHAM: Let him finish the
 2 question.
 3 Q. Let me finish my question.
 4 You've said "word of mouth." Explain
 5 to me specifically, word of mouth between who
 6 and who is somehow going to lead this family in
 7 Florida to know specifically that this heart
 8 came from one individual person in Idaho that
 9 had an intracranial hemorrhage.
 10 **A. Let's -- let's say that there's**
 11 **friends, that one friend works in Idaho and**
 12 **other works at the Mayo Clinic --**
 13 Q. But they don't know it's coming from
 14 Idaho.
 15 **A. Well but they know there will be donor**
 16 **and they will match the time.**
 17 Q. How --
 18 **A. Yeah.**
 19 Q. Match what times?
 20 **A. Yeah.**
 21 Q. What are you talking about?
 22 MR. BRANTINGHAM: Hold on one second.
 23 You're -- you're explicitly asking him to
 24 speculate. Now you're getting upset that he's
 25 speculating as you're asking him to, I mean --

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1 MR. THOMPSON: No. Because what he's
 2 saying is ridiculous. It's patently wrong and
 3 ridiculous.
 4 **A. No, no, no.**
 5 MR. BRANTINGHAM: Hold on. Just hold
 6 up. Just, doctor, hold up.
 7 **A. No, no, no. I don't --**
 8 **Listen, --**
 9 Q. And I'm going to be incredulous about
 10 it.
 11 **A. -- I'm not going to accept any insults**
 12 **from you.**
 13 Q. Okay. So stick with my question.
 14 **A. Can you retract your insults?**
 15 Q. Stick with my --
 16 No.
 17 **A. Can you retract your insult?**
 18 Q. What you're saying --
 19 **A. Don't insult me.**
 20 Q. What you are saying makes no sense to
 21 me, and so I am trying to figure out what it is
 22 that you're saying.
 23 **A. Well you have --**
 24 MR. BRANTINGHAM: Please let him
 25 explain.

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1 Q. First let me ask the question.
 2 **A. Yeah. I already answered to you.**
 3 **There could be somebody in the Idaho hospital**
 4 **that is a friend of somebody as a whole -- at**
 5 **Mayo that, you know, knows about the donor and**
 6 **they will -- can be talking to each other, so we**
 7 **cannot reveal any details of the case. And that**
 8 **is the way it's mandated and I don't have to**
 9 **explain it to you any further.**
 10 Q. Got it. You realize that even this
 11 part of the guidance that says cause of death
 12 should not be given, Mr. Brantingham didn't read
 13 the rest of that sentence, did he, where it says
 14 "unless the information is clinically relevant
 15 to the transplant recipient informed consent
 16 discussion." Do you see that part that Mr.
 17 Brantingham left out?
 18 MR. BRANTINGHAM: I didn't actually
 19 read any of it. I had the witness read it,
 20 but --
 21 Q. Oh, you left it out then.
 22 **A. I -- I read that, so all the relevant**
 23 **information was disclosed to Mr. Noah.**
 24 MR. BRANTINGHAM: And what's -- what's
 25 the language you're talking about? Because he

35 (Pages 134 to 137)

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1 read number four.
 2 MR. THOMPSON: Right -- right. No.
 3 "specific age or circumstance of death..."
 4 Oh, you had him read number four?
 5 MR. BRANTINGHAM: Yeah. That's when
 6 you put the document in front of the witness.
 7 Q. It's --
 8 Isn't this also --
 9 MR. THOMPSON: Stop. Stop.
 10 Q. Are you telling me that you think that
 11 number four here overrules your legal obligation
 12 to provide informed consent to your patients?
 13 **A. I do prefer --**
 14 **I do provide informed consent.**
 15 Q. Wasn't my question.
 16 **A. I don't know. I don't know.**
 17 Q. Okay.
 18 **A. I -- I provide informed consent to the**
 19 **patient. All the thing that you can do is**
 20 **speculation.**
 21 Q. All right. Let's do some more talk
 22 about informed consent.
 23 You told Mr. Brantingham now after the
 24 break that hundred percent of the time, when you
 25 talk to a patient in an outpatient setting, you

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1 talk to them about the heart in a box.
 2 **A. Yes, sir.**
 3 Q. Okay. What do you tell them?
 4 **A. That there's, you know, different ways**
 5 **of preserving the heart; one is cold storage**
 6 **that allows four hours, and then we have OCS,**
 7 **you know, the heart in a box, that give us at**
 8 **least eight hours, but we don't know actually**
 9 **how long, and that's it.**
 10 Q. You don't tell them anything else.
 11 **A. It's a -- it's --**
 12 **That it's a good tool that is**
 13 **equivalent to cold storage.**
 14 Q. Do you tell them about the results of
 15 the PROCEED trial?
 16 **A. Not as specifically.**
 17 Q. Why not?
 18 **A. Because if I have -- start talking**
 19 **about all the trials, you know, I'll finish, you**
 20 **know, in several years.**
 21 Q. I'm not talking about all the trials.
 22 I'm just talking about one trial.
 23 **A. Well this --**
 24 **I mean if you see the literature,**
 25 **there's around 20 studies on heart**

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1 **transplantation with the OCS device. So I talk**
 2 **to each one, it will be completely irrelevant.**
 3 Q. Did you know that your friends at
 4 TransMedics specifically say physicians and
 5 patients should be aware of the results of the
 6 PROCEED trial?
 7 MR. BRANTINGHAM: Object to the form of
 8 the question.
 9 **A. Yeah.**
 10 Q. Do you see that?
 11 **A. All right. I -- I haven't read this.**
 12 Q. Okay.
 13 **A. I --**
 14 Q. So this is --
 15 **A. But -- but --**
 16 MR. BRANTINGHAM: Just let him -- let
 17 him ask a question.
 18 **A. You ask me something. So but as, you**
 19 **know, I told you the answer that the study was**
 20 **equivalent, the PROCEED II trial says that it's**
 21 **equivalent.**
 22 Q. Okay.
 23 **A. So I, indirectly, I -- I tell them.**
 24 Q. Great. So now I'll ask you a different
 25 question.

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1 **A. But I do not ask about the PROCEED.**
 2 Q. Right.
 3 **A. That would be completely irrelevant.**
 4 Q. Do you tell your patients that in the
 5 PROCEED trial overall survival was lower for OCS
 6 patients than in patients who were given hearts
 7 preserved with cold static preservation?
 8 **A. That's wrong. It's not significant.**
 9 Q. What's that?
 10 **A. That's wrong. It's not significant.**
 11 Q. Wrong and not significant.
 12 Are you going to tell your friends at
 13 TransMedics that they should edit that part of
 14 their user manual that says physicians and
 15 patients should know about that?
 16 MR. BRANTINGHAM: Object to the form.
 17 Q. Go ahead and read it. I'm putting it
 18 in front of you like Mr. Brantingham wants me
 19 to. Read that bullet point to yourself. Read
 20 that whole thing and tell me when you're done.
 21 **A. (Witness complying.)**
 22 **Well when I --**
 23 Q. Just --
 24 Sorry. I told you to read it and tell
 25 me when you're done. Are you done?

36 (Pages 138 to 141)

<p style="text-align: right;">Page 142</p> <p>1 A. Yeah, I'm done.</p> <p>2 Q. Do you comply with that?</p> <p>3 A. They are not my governing tool,</p> <p>4 TransMedics.</p> <p>5 Q. So is your answer "No, I do not comply</p> <p>6 with that?"</p> <p>7 A. They -- I'm --</p> <p>8 I do not have compliance issues with</p> <p>9 TransMedics, so I -- I -- there's no compliance</p> <p>10 with TransMedics.</p> <p>11 Q. Do you do --</p> <p>12 A. I'm a customer.</p> <p>13 Q. Do you do what this part of the manual</p> <p>14 tells you to do?</p> <p>15 A. Indirectly, yes.</p> <p>16 Q. How?</p> <p>17 A. When I said that it's around the same</p> <p>18 results.</p> <p>19 Q. Right. You tell them something that's</p> <p>20 completely different and contradictory to what</p> <p>21 this tells you to tell them.</p> <p>22 A. Well -- well you could read the whole</p> <p>23 article and you will see that there's no</p> <p>24 significant difference.</p> <p>25 Q. Okay. Listen to my question, please.</p>	<p style="text-align: right;">Page 144</p> <p>1 A. (Witness shaking head.)</p> <p>2 Q. Your answer?</p> <p>3 A. No, they are not a governing body. I</p> <p>4 do not do what their website says.</p> <p>5 Q. Okay. This came off the FDA website --</p> <p>6 A. Uh-huh.</p> <p>7 Q. -- for your information.</p> <p>8 A. Okay.</p> <p>9 Q. So you don't do what the FDA website</p> <p>10 says.</p> <p>11 A. Yeah.</p> <p>12 MR. BRANTINGHAM: Well foundation and</p> <p>13 form.</p> <p>14 Q. Well I can bring it up on the computer,</p> <p>15 but --</p> <p>16 A. No. You told me that it was a</p> <p>17 TransMedics sign.</p> <p>18 Q. No. I told you it's the TransMedics</p> <p>19 manual --</p> <p>20 A. Well then --</p> <p>21 Q. Hold on.</p> <p>22 A. All right.</p> <p>23 Q. We can't talk over one another.</p> <p>24 A. Yeah. You should follow that advice to</p> <p>25 yourself.</p>
<p style="text-align: right;">Page 143</p> <p>1 Is it your testimony --</p> <p>2 A. Listen to my answer.</p> <p>3 Q. Is it your testimony that when you</p> <p>4 advise patients about the OCS, you actually tell</p> <p>5 them something contrary to what the manufacturer</p> <p>6 advises you to tell them?</p> <p>7 A. Well it's not contrary. It is that</p> <p>8 the -- it's lower, but it's not significant, so</p> <p>9 it needs more elaboration there to get the --</p> <p>10 the fact to be truth. So it's not</p> <p>11 contradictory.</p> <p>12 Q. When you meet with patients and tell</p> <p>13 them about the heart in the box, do you provide</p> <p>14 them with the OCS Heart System Patient Brochure?</p> <p>15 A. No. I'm not --</p> <p>16 Q. Do you --</p> <p>17 A. -- not a representative of the company.</p> <p>18 Q. Do you provide your patients with any</p> <p>19 written materials?</p> <p>20 A. Probably the transplant coordinators,</p> <p>21 but I do not.</p> <p>22 Q. Got it.</p> <p>23 So "Patients should review the OCS</p> <p>24 Heart System Patient Brochure," you don't comply</p> <p>25 with that part either; do you?</p>	<p style="text-align: right;">Page 145</p> <p>1 MR. BRANTINGHAM: Please go ahead and</p> <p>2 let's have a question. And just let him --</p> <p>3 MR. THOMPSON: We do have a question.</p> <p>4 MR. BRANTINGHAM: -- finish, doctor,</p> <p>5 and then let's have an answer.</p> <p>6 Q. Go ahead and just read that to yourself</p> <p>7 and tell me when you're done.</p> <p>8 A. (Witness complying.)</p> <p>9 I'm done.</p> <p>10 Q. You don't do that either; do you?</p> <p>11 A. No.</p> <p>12 Q. And the reason you don't do these</p> <p>13 things is because you're not governed by</p> <p>14 TransMedics; right?</p> <p>15 A. I'm not governed by TransMedics, nope.</p> <p>16 Q. TransMedics is good enough to pay for</p> <p>17 you to stay at the Ritz-Carlton in Saint Thomas,</p> <p>18 but not good enough to give you information</p> <p>19 about their own device to pass along to your</p> <p>20 patients.</p> <p>21 MR. BRANTINGHAM: Hang on. I'll object</p> <p>22 to the form and the argumentative nature of the</p> <p>23 question. You can answer.</p> <p>24 A. I went to investigators meeting in</p> <p>25 TransMedics. I'm interested in academic work</p>

37 (Pages 142 to 145)

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1 **and to provide life-saving, cutting-edge therapy**
2 **to the patients. Other than that, there's no**
3 **conflict of interest.**
4 Q. Do you think TransMedics is a good
5 company?
6 **A. They have produced a device that have**
7 **resulted in increasing -- in increasing heart**
8 **transplants and increasing, you know,**
9 **life-saving procedures. In that sense, they are**
10 **a good company.**
11 Q. Do you think that the device is a good
12 device?
13 **A. Yes, that's why I use it.**
14 Q. Do you think it is a well-designed
15 device?
16 **A. Yes, I think it is well designed.**
17 Q. So TransMedics has put out a
18 well-designed, good device that you use for your
19 patients all the time; right?
20 **A. That is approved by the FDA.**
21 Q. That's approved by the FDA as well.
22 Their manual is also approved by the
23 FDA; is it not?
24 MR. BRANTINGHAM: Foundation.
25 Q. If you know.

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1 **A. If you tell me, I can't -- I have no**
2 **reason not to believe you.**
3 Q. When you were at this meeting in
4 Prague, were you there with Dr. Knop?
5 **A. I don't remember if he went or not.**
6 Q. I will tell you that he testified under
7 oath this morning that he attended the
8 International Society of Heart and Lung
9 Transplantation meeting in Prague. That's the
10 same meeting that you were talking about when
11 somebody from TransMedics came up to you and
12 said some lawyer's been sniffing around; right?
13 MR. BRANTINGHAM: Object to form.
14 **A. Well again, I don't have any reason not**
15 **to believe you. You're making a statement. I**
16 **have no reason not to believe you that Knop --**
17 **Dr. Knop went to Prague to the IHLT meeting.**
18 Q. Dr. Knop testified that during one of
19 the question-and-answer sessions he got up and
20 he actually provided information about what
21 happened in this case. Did you know that?
22 **A. I didn't know that.**
23 Q. So you must not have been at that
24 question-and-answer session.
25 **A. Not that I remember.**

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1 Q. Were there other Mayo folks from your
2 department who were at the meeting?
3 **A. I remember Dr. Spencer was there.**
4 Q. Uh-huh.
5 **A. From lung transplant, Dr. Saddoughi.**
6 Q. Do you know if this directive that you
7 gave to the people who wanted to do the case
8 report to keep this whole thing under wraps went
9 to Dr. Knop as well?
10 MR. BRANTINGHAM: Object to the form of
11 the question.
12 **A. That was -- that was not the directive.**
13 Q. The directive was "We're not going to
14 publish anything about this outside of Mayo
15 until the lawsuit's over."
16 MR. BRANTINGHAM: Object to form. You
17 can answer.
18 **A. Yeah. Let's -- let's wait.**
19 Q. Okay. So the directive to not talk
20 about this outside of Mayo until the lawsuit's
21 resolved, was that passed on to Dr. Knop as far
22 as you know?
23 **A. I don't know about that. I remember**
24 **he --**
25 **I don't remember him doing the case-**

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1 **report work. I remember the transplant fellow**
2 **and a guy from intensive care that I don't**
3 **remember his name, but I don't know anything**
4 **about Dr. Knop.**
5 Q. And you told me --
6 **A. In terms of case reports.**
7 Q. Do you remember the name of the
8 transplant fellow?
9 **A. Yeah, actually. Chauhan.**
10 Q. Spell that for us, please.
11 **A. A-k-s-h-a-i space C-h-a-u-h-a-n.**
12 Q. Is that a he or a she?
13 **A. He.**
14 Q. Is he still here at Mayo?
15 **A. No. He finished his transplant**
16 **fellowship.**
17 MR. BRANTINGHAM: It's the one in the
18 medical record that you've asked about.
19 MR. THOMPSON: That's the one that
20 we're -- yep. Got it.
21 Q. The cardiology person who wanted to do
22 a case report, do you remember his or her name?
23 **A. No. They are -- you --**
24 **Intensive care I think is most likely,**
25 **not cardiology, intensive care fellow. I**

38 (Pages 146 to 149)

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1 **don't -- I don't remember.**
 2 Q. Do you --
 3 **A. But I remember receiving an email about**
 4 **data. I said wait, please.**
 5 Q. You got an email from them about it.
 6 **A. Yeah.**
 7 Q. And did you respond via email as well?
 8 **A. Yeah, yeah. The --**
 9 **I believe so. Yeah.**
 10 MR. THOMPSON: I'll go ahead and
 11 request that. All right.
 12 MR. BRANTINGHAM: I didn't totally
 13 track the description of it, but I'm sure that
 14 you will send a follow-up communication.
 15 (Discussion off the record.)
 16 BY MR. THOMPSON:
 17 Q. If the family, Noah's family, testifies
 18 that neither you nor anybody else told them
 19 anything about the OCS, are you going to deny
 20 that?
 21 **A. I, again, you know, I cannot be a**
 22 **hundred percent sure, but very likely I talked**
 23 **to him about it.**
 24 MR. THOMPSON: All right. I don't have
 25 any other questions.

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1 MR. BRANTINGHAM: I don't have any
 2 questions. We will read and sign.
 3 THE REPORTER: Okay. Thank you. Off
 4 the record.
 5 (Deposition concluded at 4:17 p.m.)
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1 CERTIFICATE
 2 I, Nicole A. Huber, hereby certify that
 3 I am qualified as a verbatim shorthand reporter;
 4 that I took in stenographic shorthand the
 5 testimony of MAURICIO VILLAVICENCIO at the time
 6 and place aforesaid; and that the foregoing
 7 transcript consisting of 151 pages is a true and
 8 correct, full and complete transcription of said
 9 shorthand notes, to the best of my ability.
 10 Dated at Baxter, Minnesota, this 20th
 11 of August, 2024.
 12
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 25

NICOLE A. HUBER
 Notary Public

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1 SIGNATURE PAGE
 2 I, MAURICIO VILLAVICENCIO, the deponent,
 3 hereby certify that I have read the foregoing
 4 transcript, consisting of 151 pages, and that
 5 said transcript is a true and correct, full and
 6 complete transcription of my deposition, except
 7 per the attached corrections, if any.
 8 PAGE LINE CHANGE/REASON FOR CHANGE
 9 _____
 10 _____
 11 _____
 12 _____
 13 _____
 14 _____
 15 _____
 16 _____
 17 _____
 18 _____
 19 Date Signature of Witness
 20
 21 WITNESS MY HAND AND SEAL this ____
 22 day of _____, 2024.
 23
 24 (NAH) _____
 25

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